Inquiry calls for doctors to be tested regularly for alcohol

Bryan Christie, *Edinburgh*

Britain's health authorities have been asked to consider the practicality of introducing compulsory medical tests for all doctors every two years to pick up early warning signs of alcohol problems.

The recommendation is made in the report of a fatal accident inquiry held into the deaths of two patients at St John's Hospital in Livingston, Scotland. They died after operations carried out by a consultant surgeon, Gerald Davies, who subsequently admitted to having a serious drink problem. He reported drinking up to half a bottle of whisky a night regularly, and the inquiry was told that his alcohol level on the following morning would have been twice the legal limit for driving.

In his written judgment, Sheriff Gordon Nicholson found that Mr Davies made a serious mistake in one of the operations that "would not have been made by any competent, experienced surgeon." Although his drinking may have played a part in the deaths, it was not possible on the evidence presented to the inquiry to conclude that this was a probability, "far less a certainty." As such, the sheriff concluded

that Mr Davies could not be held to be responsible for the deaths of the two patients.

But he criticised the hospital for failing to respond to concerns reported by staff about Mr Davies's drinking over the two years before his suspension. Sheriff Nicholson said that there seemed to be no clear procedures for dealing with such concerns and added: "There appears to be a culture among members of the medical profession where it is regarded as inappropriate, or in some instances potentially injurious to future career prospects, to report on certain matters, including in particular a colleague's apparent excessive drinking."

James Griffith Edwards, emeritus professor of addiction behaviour at the University of London, said in his evidence to the inquiry that recent surveys have shown that doctors may be heavy drinkers for as long as seven years before anything is done to tackle the problem. He said that health service trusts should have the power to order mandatory medical tests for doctors suspected of having an alcohol problem—a suggestion backed by the sheriff.

Gerald Davies admitted to having a serious drink problem

Professor Griffith Edwards also spoke in favour of mandatory tests, including liver function tests, every two years for all doctors. Sheriff Nicholson acknowledged that such a scheme carried significant resource implications but said that it merited consideration.

Arthur Morris, chairman of the Scottish Council of the BMA, said that he fully support-

ed the report's recommendations on improving the monitoring of alcohol problems. "All health professionals need access to high quality occupational health services so that health problems can be detected and support given at an early stage," he said. The Scottish Health Department said that it would be considering the recommendations. □

NHS "good news unit" to be wound up

Judy Jones, *London*

The NHS intelligence unit that helps ministers put a positive gloss on politically damaging "horror stories" is set to be wound up as part of an efficiency drive.

The Corporate Affairs Intelligence Unit of the NHS Executive, otherwise known as the "good news unit," was set up in

1993. In four years the unit has given ministers early warning of a range of potentially explosive incidents likely to attract media and parliamentary interest, from deaths of patients while awaiting treatment to gathering protests over closures of hospitals or accident and emergency departments. The unit's remit also required its staff to find and promote "good news stories" to counterbalance the bad.

Now it has become the latest target of Health Secretary Stephen Dorrell's drive to cut management costs. Its imminent demise also reflects a growing

confidence among ministers that the political arguments, if not the rhetoric, about the internal market reforms of the health service have been largely neutralised.

However, the unit is not likely to be disbanded until after the general election. It was created in 1993 at the height of Virginia Bottomley's troubled and unpopular stewardship of the NHS as health secretary. The political damage to the Conservatives caused by the regular stream of NHS horror stories was acknowledged a year later in a memo by John Maples, then deputy party chairman. He

wrote that the best the Tories could hope for was "zero media coverage" of the health service.

The unit of 30 officials operate from Quarry House, the Leeds headquarters of the NHS Executive, independently of the press and publicity departments of the executive or the Department of Health. It costs more than £1m (\$1.6m) a year to run.

The intelligence unit has been targeted under a strategy agreed by ministers in December 1994 to devolve more management and administration functions to the regional health authorities of the NHS. □

Insurance scheme planned for elderly care

John Warden,
parliamentary correspondent, BMJ

Two government white papers this week propose changes to the way older people are cared for in Britain.

One plans to help people protect the value of their homes and capital from being used to pay for residential care. The other would introduce a purchaser-provider system into local authority social services, with councils having to divest themselves of directly run residential homes.

The imminence of a general election within weeks rules out action in the present parliament and transforms the white papers into manifesto commitments dependent on the Conservative Party being re-elected. Both address the concept of "cradle to grave" health care and the anomaly of care in the NHS being free but social care of elderly people being means tested. This has been so since 1948, but demographic change has raised the political profile of the issue.

To deal with the perceived injustice of means testing, which bears on those who have built up lifetime capital, the government entitles the first white paper *A New Partnership for Care in Old Age*. Older people would, in effect, insure for two or three years' residential or nursing home care. When that is exhausted the government would give £1.50 (\$2.40) protection of assets for every £1 insured.

A man of 70 would pay a premium of £6800 to exempt £80 000 of capital from a means test. For a woman, the cost would be £10 800. The government expects the scheme to be widely affordable from lump sums paid by private pension schemes when people retire.

The second paper, *Social Services: Achievement and Challenge*, would focus the role of social service departments in England and Wales on assessment and commissioning of care and would use the private sector to provide care in homes and by domiciliary services. □

Faecal contamination of animals in abattoirs is a cause for concern

Red faces over red meat

John Warden,
parliamentary correspondent, BMJ

The British government denied last week that it had suppressed a year old report by its own meat inspectors which stated that abattoirs had become breeding grounds for *Escherichia coli*.

When the report came to light in press leaks, ministers were wrongfooted by having to admit that they had not seen it. Neither had the report been passed to Professor Sir Hugh Pennington, who is heading the

Scottish Office inquiry into the *E coli* outbreak in Scotland that killed 20 people. Professor Pennington expressed his dissatisfaction with the situation.

The official explanation is that the report, *Red Meat*, was a "working document" within the government's Meat Hygiene Service; action had already been taken on its findings; it had been discussed within the meat industry; and it had been freely available on request. It also seems that civil servants failed to appreciate the political sensitivity of the issue.

The revelations, within 60 days of a general election, seriously embarrassed the government—especially the Ministry of

Agriculture, Fisheries and Food and its embattled minister, Douglas Hogg. Mr Hogg, who has been criticised for his handling of the beef crisis, which led to a world ban on the export of British beef because of bovine spongiform encephalopathy, admitted a collapse of public confidence in food safety. The abattoir scare has given impetus to Labour party proposals for an independent food standards agency (8 February, p 395).

Several versions of the Red Meat report have emerged. One draft said that major faecal contamination on animals arriving at abattoirs was a serious cause for concern: "Organisms such as *E coli* O157 and salmonella can be introduced into the plant on the skins of dirty livestock." Another worry was the washing of offal in static tubs of water.

Profits at Britain's 469 abattoirs have been hit by a fall in demand for beef. But operators maintain that dirty cattle are routinely sent back to the farm. When the washing of livestock was tried at abattoirs in New Zealand the bacterial count was found to be higher than that in unwashed beasts.

Although the Scottish *E coli* outbreak was traced to a retail butcher, the final Pennington report will also cover cross contamination of carcase meat in abattoirs. □

UK Labour party plans health changes by evolution

Linda Beecham, BMJ

If the Labour party wins the general election it will end the internal market in the NHS, which it believes has led to fragmented decision making, inequity in the access to care, and increased bureaucracy.

But the shadow health secretary, Chris Smith, assured the BMA's consultants committee last week that his party planned to introduce changes by evolution rather than changing everything at once. Single practice fundholding will be replaced with locality purchasing. Locality groups would negotiate with the provider unit for services for the whole area. This, Mr Smith said, would create greater stability and do away with two tierism,

whereby patients of fundholders are treated ahead of those of non-fundholders irrespective of clinical need.

To reduce bureaucracy and the amount of paperwork, annual contracts and individual patient invoices would be abandoned. The shadow minister thought that it might be possible to reduce the number of health authorities.

Mr Smith criticised what he called the bean counting phenomenon. It was no good measuring quantity if there was no information about quality and effectiveness. The efficiency index would be scrapped in favour of an effectiveness assessment. He admitted that this would be difficult, and he

promised exploratory discussions with the BMA and the medical royal colleges.

The Labour party has already pledged itself to appointing a minister for public health and to banning tobacco advertising. This, Mr Smith told the consultants, was part of the aim of putting a real effort into promoting public health. He would also like to see an independent food standards agency.

In answer to a question about NHS funding, Mr Smith hoped that, although he could not offer extra money, savings could be made by ending unnecessary processes. His party had accepted the government's funding settlement for the forthcoming year, but he hoped that in the next financial year it might be possible to rearrange priorities within the overall spending total.

The shadow health minister also promised to end local pay for nurses. □

Norwegian GPs move to list based system

Sandra Goldbeck-Wood, *BMJ*

Norway is to introduce a list based system for GPs if government policy is ratified by parliament this spring.

The new policy was announced by Dr Gudmund Hernes, Norway's health minister, in a labour party national board meeting last month and will be put before the spring session of parliament shortly.

This is the first time that the Norwegian government has publicly backed the idea of a list sys-

tem. The measure follows a pilot project that has been carried out in four municipalities and ended last autumn.

Until now Norway has operated an open access system in general practice. Dr Steinar Westin, professor of general practice at Trondheim University, said that this has led to a lack of continuity of care and duplication of work. "There has been a lot of 'doctor shopping,' especially in the larger towns and cities, and doctors find this very inefficient and frustrating."

Dr Trine Normann from the Department of Health described the old system as "confused," with a mixture of private and state reimbursed doctors providing a patchy service that left some of Norway's more remote

communities poorly served. "This has meant big problems for patients and restricts the authorities' ability to regulate services and costs," said Dr Normann.

All four areas that piloted the scheme have decided to continue with the new system. Patients were generally satisfied with the new arrangements, citing reduced waiting times, greater continuity, and an increased feeling of security as advantages of the new system.

Patient groups have not been consulted formally, however; and while elderly people and chronically ill patients were particularly enthusiastic, younger patients placed more emphasis on autonomy and choice.

Most doctors participating in the project believed that the

new system should become permanent, and the measure has the backing of Norway's college of general practitioners and of the Norwegian Medical Association.

Rural GPs were more guarded in their enthusiasm, fearing that the changes might have a negative impact on recruitment to remote regions. By favouring long term commitment to a particular area, the system could discourage applications to work in those geographically inhospitable areas that depend on a high turnover of doctors working for limited periods.

Another difficulty identified was that some GPs' lists became very much longer than others, which led to a wide disparity in capitation based income. □

South African research into AIDS "cure" severely criticised

Pat Sidley, *Johannesburg*

Research into a cure for AIDS conducted by a Pretoria University team has been condemned by a team of experts that has looked into the claims of the team and found them seriously wanting. A joint inquiry by the Gauteng Health Department and University of Pretoria found no scientific evidence that the drug, called Virodene P058, inhibits progression of HIV infection (8 February, p 450).

The drug contains a toxic industrial solvent called diethylformamide. The chairman of the inquiry committee, Professor Henk Huismans, told reporters that the preclinical trial research and experiments were so "sloppy" that the results of the clinical trials could not be determined with any degree of certainty. The researchers contravened accepted scientific procedures by proceeding with a clinical trial in which patients with AIDS were exposed to the industrial solvent, which Professor Huismans said was its only ingredient.

The researchers had claimed there was well documented evidence for the antiviral action of diethylformamide as an inhibitor of HIV protease, but the committee found that the quoted evidence did not support this conclusion.

The research team had con-

ducted its experiments on patients with AIDS without the required permission of the Medicines Control Council or the Ethics and Research Protocol Committee of the University of Pretoria.

The committee was concerned at the lack of specific scientific skill in internal medicine, virology, and toxicology among the team and said that without this expertise it would be impossible for the researchers to continue their research—and they would not get permission to do so from the controlling bodies.

Other matters for concern included the lack of a proper control group, the way patients were selected for the trial, and the secretive, non-transparent nature of the investigation.

The committee said that the decision by the research team to use preliminary data to attract funding from government sources had "bypassed all the conventional funding and controlling bodies who would normally be expected to use a high level of scientific scrutiny to judge applications for financial support." This was a reference to the fact that the team had taken the issue to the minister of health, Dr Nkosazana Dlamini-Zuma, who had presented the now discredited results to the

The drug Virodene P058 did not have a proved action against HIV

cabinet, which in turn seemed to be willing to fund further research. It was the leak of this event to the media that brought the whole issue to the public eye and belated scientific scrutiny.

Another issue that concerned the committee was the setting up of a private company owned by one of the researchers, Olga Visser. The committee viewed it as a potential conflict of interests among the university, the company, and the team of researchers.

The door for further research has, however, been left open. The committee, as well as the Medicines Control Council, stated that if a new research team wanted to begin the process from the beginning, observing the required scientific and ethics protocols, it could submit proposals to the Medicines Control Council and the ethics committee for evaluation.

The research team, scalded by the rebuke, has threatened legal action, saying that the committee's report "spread misinformation and is contradictory." In response the Gauteng Health Department said that it would be asking the South African Interim Medical and Dental Council to consider investigating the researchers for professional negligence or misconduct.

Dr Dlamini-Zuma, who has not quite recovered from an earlier AIDS related scandal—she commissioned a musical called *Sarafina 2* on AIDS issues at a cost to the country of 14m rands (£1.96m, \$3.13m)—expressed her support for the team and urged that the research continue. This has drawn fire from the media, with the influential daily newspaper *Business Day* referring to the Virodene issue as "Parafina 2." □

China bans smoking on trains and buses

Richard Tomlinson, *Beijing*

China is to ban smoking on its public transport system from 1 May, the latest in a series of government regulations designed to encourage the world's biggest nation of smokers to stub out their cigarettes.

The ban will cover railway carriages, ship and aeroplane cabins, buses, subways, and taxis, as well as ticket halls and waiting rooms. However, smoking will be allowed in specially designated areas, in particular the connecting passageways between train carriages, which may raise new safety concerns. The announcement was made last week by the National Committee for Patriotic Health Campaign and by five ministries.

As always in China, any restriction on smoking is only as good as the government's commitment to enforcement. The official surveys show, for instance, that about 60% of all train passengers smoke. The penalty for breaking the new regulations will be a fine of 10-50 yuan (77p-£4; \$1-\$6), but it is not clear how this will be imposed or by whom.

As the government has become aware of the immense

health risks and costs for a nation with 300 million smokers, public education and restrictions on smoking in public places have become much more active in China over the past two years. The Chinese Academy of Preventative Medicine has forecast that by 2030 there will be about 3.2 million smoking related deaths in China annually. In August this year Beijing will host the 10th world conference on tobacco and health, with participants from more than 130 countries.

Perhaps with this as a spur, Beijing, Shanghai, and about 40 medium and small cities have prohibited smoking in public places over the past couple of years, although the definition of a public place is quite narrow and enforcement can be patchy. At Beijing's main airport the waiting lounges are now smoke free zones. Domestic flights are no smoking, for example, but sports stadiums, restaurants, and government offices are not. Restrictions have also been imposed on tobacco advertising, banning it from television, radio, newspapers, and magazines, but companies often bypass these constraints by concentrating on

The number of smokers is increasing in China

sponsorship deals. Despite government policy, surveys show that the number of smokers is increasing in China, with young people and women the biggest growing markets. Until recently it was very rare to see a young woman smoking, but at least 10% of women over 15 now smoke.

One antismoking drive that has been successfully imposed on an unwilling audience is at this year's annual meeting of

China's parliament, the National People's Congress. The prime minister, Li Peng, was so horrified at the dense clouds of smoke at last year's conference that he banned smoking in the Great Hall of the People for this month's meeting. The 3000 or so delegates, mostly men and mostly smokers, have duly restrained themselves, although the tea rooms are rather emptier this year. □

Dutch move to end consultants' freedom

Tony Sheldon, *Utrecht*

After five years of negotiations the first step has been taken to integrate Dutch consultants into the hospital management structure and limit their freedom to act as self employed entrepreneurs.

With the exception of consultants in university hospitals, who are paid a salary, most of the 13 000 hospital consultants, or medical specialists, in the Netherlands charge their patients fees for services that are based on national tariffs. The patient receives a separate bill from the hospital.

Under the new legislation,

which health minister Professor Els Borst-Eilers laid before parliament last week, patients will receive a single bill from the hospital. Health insurers will contract for specialist care either directly through the hospital or through a cooperative association of the hospital and consultants.

The option of setting up a cooperative association was added at the last moment to allay fears that consultants' professional independence will be lost and to preserve their free-lance status with its tax benefits.

But the Dutch Hospitals Association argues that the new law would be a "catastrophe for hospital management." The association's director, Cees de Jong, argued that it would become unclear who had the final responsibility for the quality of patient care, taking hospitals back 20 years to the time when the hospital ran the beds and nurses and

doctors were in charge of the patients. He argues: "Someone has to be in charge and take financial responsibility of the whole enterprise, including the doctors."

The Association of Medical Specialists attacked the proposed law as "unnecessary and undesirable." It fears that the vague cooperative associations could endanger professional autonomy. The association's chairman, Dr Jan Herre Kingma, said: "They want us to work more like employees under contract to the hospital. That is a step too far. We want to remain independent." He wished to see the "tripartite arrangement" maintained whereby consultants negotiate as equal partners with hospitals and insurance companies.

Reform of the system of payments for specialist care has been urged since the late 1980s,

when costs rose 22% in three years while the number of patients treated increased only 5.2%.

In a bid to curb costs the government forced cuts in consultants' tariffs for two years running. Now most consultants have been forced to take part in local experiments with new remuneration systems to avoid further cuts in tariffs.

In 1994 an inquiry by former prime minister Barend Biesheuvel recommended integrating consultants by creating "medical specialist companies" within hospitals and paying a basic salary with supplements for irregular hours and heavy workloads (29 January, p 290).

The current cabinet is committed to progress along Biesheuvel's lines, although the new law is seen as favouring consultants over hospital managers. □

Citizens juries vote to extend nurse roles

Jenny Bryan, *London*

Expanding roles for pharmacists and nurse practitioners and practical improvements in gynaecological cancer services are among the latest recommendations to come from a programme of citizens juries, supported by the King's Fund.

The decisions come as a report from the Fabian Society out this week calls for wider use of citizens juries, saying that they can help health authorities improve their decisions and build public confidence.

The authors say: "In attempting to understand the public's perspective, too many elected representatives rely only on a self selected sample of people who come to them via special interest groups. No wonder their messages fail to engage."

Jurors sitting in Sunderland,

where there is a shortage of GPs, spent four days listening to expert and patient evidence before making recommendations including:

- Continued development of nurse practitioner pilot schemes attached to general practice
- Extension of the pharmacist's role in providing drug advice to GPs and monitoring repeat prescriptions (but not extending to diagnosis and initial prescription of drugs)
- Exploring models for employing salaried doctors, ready for new primary care legislation

Maureen Dale, quality manager at Sunderland Health Authority, said: "Many of the recommendations fit in with health authority plans and we will certainly be considering them at our next meeting in May."

In east Sussex, where gynaecological cancer services are fragmented, the jury was unanimous in recommending that the health authority should centralise services in Brighton and not leave individual hospitals to set up local centres linked to teaching hospitals.

Other recommendations included:

- Ending discrepancies in standards of care and treatment, waiting times, and facilities
- Improving availability of counselling to patients from diagnosis onwards
- Reviewing and unifying data collection

Zoe Nicholson, commissioning and primary care development manager, at East Sussex, Brighton and Hove Health Authority, said: "We couldn't have come up with better answers, but getting this degree of change will be difficult because of disagreement among clinicians nationally about where gynaecological cancer should be treated. The jury has given us a

steer for planning services in this area."

Other citizens juries coordinated by the Institute of Public Policy Research and drawn from cross sections of the general public in Portsmouth, Walsall, and Kensington and Chelsea have already reported on mental health and palliative care issues, and a final jury, in Buckinghamshire, was this week completing its recommendations on the management of back pain. The King's Fund will then evaluate the success of the programme.

"At £13 000-£20 000 [\$21 000-\$32 000] for each meeting, the jury system is quite an expensive form of consultation compared to focus groups, surveys, and public meetings," said Susan Elizabeth, grants director at the King's Fund.

"We must now decide for what kinds of issues the citizens juries are a better method of consultation than anything that health authorities already have available," she added. □

Care of schizophrenic man strongly criticised

Clare Dyer, *legal correspondent, BMJ*

A schizophrenic man who killed his stepfather and left his mother for dead was let down by professionals in health, housing, and social services, according to an independent report published last week.

Social workers, psychiatrists, and housing managers were criticised for "fundamental and depressing" failures, in what was said to be one of the most damning reports of its kind. Professionals in the separate agencies "did not seem to be talking to each other," the report said.

Martin Mursell, aged 28, stabbed his disabled stepfather Joseph Collins 18 times and his mother, Mary Collins, six times, at their flat in Islington, north London, in October 1994. Convicted of Mr Collins's murder and the attempted murder of Mrs Collins, he is now serving a life sentence in Rampton special hospital. He had a history of violence and multiple drug misuse

A breakdown of care?

and had previously threatened to "do a Hungerford" and "cut the bitch's [his mother's] head off."

The inquiry report, commissioned by Camden and Islington Health Authority, found that there was "a breakdown of care" between 3 August 1994, when he was discharged from the Waterlow Psychiatric Unit in north London, and 28 October, when he committed the offence. But the inquiry team, chaired by Lincoln Crawford, a barrister, upheld the principle of care in the community. Mr Crawford said that the answer was not "to

reopen Victorian asylums" but to get the procedures for community based care right.

Martin Mursell was admitted to the Waterlow unit as a voluntary patient in July 1994 and discharged three weeks later. The report criticises two psychiatrists, Norman Harvey and Jason Taylor, for failing to take the risk to others sufficiently into account when discharging him. His care plan on discharge was "woefully inadequate" because there was no key worker, no allocated social worker, and no meaningful involvement by the commu-

nity mental health worker.

The strongest criticisms are for the London Borough of Islington's housing department, which repeatedly placed Martin Mursell in bed and breakfast accommodation "which was wholly inappropriate for his needs," and left the flat originally allocated to him in disrepair for more than a year after damage caused by Mursell and by vandals and squatters. Islington's social services department is criticised for allocating Mursell's case to someone who was not an approved social worker and had no mental health experience.

David Stout, director of mental health services for the NHS trust, said: "The three agencies have drawn up an initial joint action plan to address the report's recommendations. There has been closer cooperation between health and local authority services over the past two years in particular with regard to the implementation of the care programme approach that was clearly missing in Martin's case."

Hannah Miller, chief social services officer for Islington, said the council had introduced specialist mental health teams since 1994 which worked closely with health workers to support mentally ill people in the community. □

Welsh Office criticised over Morryston affair

Roger Dobson, *Gwent*

The Welsh Office has been criticised for not intervening sooner in the growing financial problems at Morryston NHS Trust, where there had been warnings of a £3.5m (\$5.6m) deficit for some time before the announcement of redundancies last August.

A report by the Parliamentary Welsh Affairs Committee also said that the redundancy programme which led consultants to pass a vote of no confidence in the chief executive and chairman of the trust should never have been necessary. The redundancies announced last August were later withdrawn after widespread condemnation (17 August, p 385).

"With all the monitoring information available to them it should have been apparent to

the Welsh Office well before July that things were going wrong. It does not require hindsight to see that they should have intervened sooner," says the report.

And it adds: "It was, and remains, convenient to the Welsh Office to blame people rather than systemic faults or lack of funding for Morryston's problems. The Welsh Office must be readier to intervene where necessary to ensure that the NHS in Wales is properly managed."

The report also criticised poor relations between the health authority and the trust. It says that even after the health authority was told of the deficit, it remained unconvinced of the seriousness of the situation. There is a warning, too, that the problems at the trust are far

from over, that expenditure continues to exceed income, and that the deficit continues to rise.

The report says that the 16 staff concerned, including three consultants, should have been redeployed six months earlier, when half the dedicated elderly care beds were transferred to the neighbouring Singleton Hospital, also in Swansea.

Although the transfer lost the trust £1.7m a year from Iechyd Morgannwg Health, it was decided at the time to retain the elderly care medical staff. But the report adds: "Given that the staff had not been redeployed, the redundancy programme was not self evidently unreasonable, though it may have been politically naive. We believe the Morryston Board acted in good faith and have good reason to feel aggrieved at the lack of support they received from both the health authority and the Welsh Office."

It also says that as the chief medical officer for Wales, Dame Deirdre Hine, was concerned

about the impact on recruitment: "We fail to understand why the Welsh Office did not make it explicitly clear to trusts, and to Morryston in particular, that medical redundancy was not an acceptable option."

Welsh health minister, Gwllum Jones, said, however: "Since last summer there has been criticism that the Welsh Office intervened too much in Morryston and now we have a report suggesting we didn't intervene enough, so putting the two together perhaps suggests that we got it about right."

The Morryston affair led to the resignation of Trust chairman, Peter Allen, who was followed by a number of board members. Chief executive, Tony Beddow, who stepped down from his post, welcomed the report which he says vindicated the management. □

Morryston Hospital: A Case Study in the Workings of the Internal Market is available from the Stationery Office, price £18.

Focus: Washington

Political allies and enemies take on junior doctor surplus

John Roberts

Change often comes in odd forms, and none is odder than the way the US government is dealing with paying junior doctors. In 1965, fearing a predicted shortage of doctors, it widened the scope of the Medicare programme, the government health insurance scheme for the elderly, and made it assume the bill for educating America's junior doctors.

This was a great success. Training programmes grew rapidly as the government paid hospitals for each junior doctor on their staff. The more juniors they had, the more money came to the hospital. And since the subsidies were more than three times the junior doctor's salary, there was plenty of

incentive to train more, and train them longer.

The programme succeeded so much that for over decade health policy experts have been decrying the large oversupply of doctors in America. Last year, the total produced was about 100 000—about 16% of all doctors in practice. Experts estimate that each doctor entering practice costs Americans about \$1m a year (£620 000) in medical costs, many of them unnecessary in a country saturated with specialists and subspecialists.

Yet because the original Medicare plan was so generous to everyone, nothing happened about this oversupply. Hospitals had no incentive to stop training doctors—rather the opposite. Private insurers, since they pay nothing, had no particular interest in ridding hospitals of cheap labour. Senior doctors, having 24 hour coverage, slept more peacefully at night.

Then in stepped an odd coalition of politicians. In the middle was President Bill Clinton, and surrounding him

were the New York hospital employees unions, which gave heavily to his re-election campaign; Bruce Vladeck, a former New York health administrator who now runs the Medicare agency that pays the hospitals; and New York senators Daniel Patrick Moynihan, a Democrat, Alfonse D'Amato, the Republican who has led the investigation of Mr Clinton's involvement in the Whitewater land scandal.

Last month this coalition announced that it would solve the doctor surplus by paying hospitals not to train doctors. The solution is good only in New York, however (1 March, p 625). Congressmen, hospital administrators, and health policy experts all applauded the idea but said it was unfair to reward New York only because of the strong political forces emanating from the big eastern state. Nevertheless, New York trains 15% of American doctors, more than any other state. Moreover, many of its teaching hospitals serve the poor, and they have to hire foreign medical graduates to fill junior

positions. American graduates will not work where junior doctor pay is so low that they do work that ordinarily would go to stretcher bearers, plebotomists, and low level nursing staff, all of whom cost more than junior doctors to pay.

Under the plan, which already has gone into effect, the hospitals will trim their junior doctor staffs by 20-25% over the next six years, and the hospitals will be paid a total of \$400m (£250m) not to fill junior doctor positions. That money will instead be used to hire lower level staff. Said Dr Alan Hillman, a professor of health policy at the University of Pennsylvania, "It's amazing to treat health care as a commodity like grain or milk or meat ... But I really can't find any fault with it. Maybe it is one of the first rational collaborations between hospitals and the government." This odd alliance of New Yorkers and Washingtonians may have put together a programme that few fault on merit and many look at with envy. □