Row over force feeding of patients with Alzheimer's disease

Tony Sheldon, *Utrecht*

Doctors in the Netherlands have argued that patients with dementia who are terminally ill should be allowed to starve rather than be artificially fed. They spoke out after the relatives of a patient with Alzheimer's disease accused a nursing home of attempted murder, claiming the home intentionally let him dehydrate.

Patients with Alzheimer's disease who consistently refuse food and drink are rarely force fed in the Netherlands in contrast to the policy in other countries such as Germany and the United States. It is argued that force feeding needlessly extends the dying phase, while starvation can offer a dignified and gentle death.

The 62 year old patient, Mr R Mulder, had suffered from Alzheimer's disease for 10 years. He had recently been admitted to hospital because of an infection and was recovering at a geriatric nursing home in Groningen. His condition deteriorated, and he fell into a coma. But his wife and daughter asked why he was not being given fluids through a drip.

They claim to have been told that it was in line with the home's "dehydration policy."

He was immediately transferred to hospital, where he regained consciousness after several hours. Specialists there have said that the family saved his life. The nursing home denies having a policy of mercy killing or dehydration but said that there had been a breakdown of trust with the patient's family. The home's policy document explicitly forbids euthanasia but recognises that life prolonging medical treatment is wrong for a patient with no hope of recovery.

Both the police and public health inspectorate are now investigating the case, and a further seven families have reported what they claim is dubious treatment at the home. Since then claims have emerged that about 50% of deaths in Dutch nursing homes could be as a result of starvation.

Dick Sipsma, professor in geriatric medicine at the University of Groningen, said that if

there was any expectation of recovery then Dutch nursing homes would consider artificially feeding patients with dementia. However, if after a thorough examination there were no somatic causes for their refusal to eat and there was a slow but general failure of physical functions: "There will come a time when you think this is torture; let's just try to give a little food and drink but not a feeding tube. It is

senseless to prolong the dying process," he said.

Dr Jos Konings, lecturer in nursing home care at the Free University of Amsterdam, said that it was entirely wrong to assume that the decision not to artificially feed patients with Alzheimer's disease was automatic. Decisions on feeding should be taken with extreme care and include all staff and the patient's relatives. □

HOLLANDE HOOGTE

Dutch patients with Alzheimer's disease are rarely force fed

For profit medicine in United States under scrutiny

Fred B Charatan, *Florida*

Three executives in America's largest for profit hospital chain, Columbia/HCA, have been indicted on fraud and conspiracy charges involving Medicare reimbursement to hospitals.

Robert Whitehouse, director of reimbursement at Columbia's headquarters in Nashville, Tennessee, Michael Neeb, chief financial officer of its northern Florida division, and Jay Jarrell, chief executive of its southwest Florida division, will appear before a federal judge on 19 August.

The indictments were handed down by a Florida grand jury after months of investigation by federal agents, who executed 35 search warrants of Columbia facilities nationwide, 20 of them in Florida. A major focus of the inquiry was Fawcett Memorial Hospital in Port Charlotte, Florida. The government alleges that the hospital falsely represented longterm debt as capital expenditure instead of loan interest, resulting in overpayments of \$1.75m (£1m). The

indictments also charge that Columbia failed to notify the government that an audit error resulted in a favourable result for the corporation and a large government overpayment.

Separately, a group consisting of several dozen insurance companies and the Blue Cross and Blue Shield plans has hired a law firm to investigate whether Columbia overcharged them by inflating costs or charging for unnecessary services.

Columbia/HCA was started in 1987 by Richard L Scott, a lawyer, who built the corporation from two small hospitals in El Paso, Texas, into a \$20bn giant with 342 hospitals, 150 outpatient surgical centres, and 570 home healthcare centres. In the wake of

the federal investigation Mr Scott has resigned, as has David Vandewater, the firm's president and chief operating officer.

Mr Scott has been replaced by Dr Thomas Frist, a surgeon who founded the Hospital Corporation of America before Columbia acquired it in 1994. Dr Frist said: "I can assure you that we take these allegations very seriously and will cooperate with the government." He also promised to stop the much criticised policy of selling Columbia hospital shares to doctors—an arrangement which investigators believe may have encouraged doctors to refer patients only to specialists at hospitals owned by Columbia even if it was not in a patient's best interests. □

In brief

Trust boards to go public: The health secretary, Frank Dobson, has asked all NHS trusts in England to open their board meetings to the public from now on, in advance of parliamentary regulations in the autumn.

AMA backs tobacco deal: The American Medical Association broadly endorsed the \$368.5bn (£230bn) settlement with the United States tobacco industry but said that the Food and Drug Administration should have more power to regulate tobacco.

Head of NHS Confederation to go to House of Lords: The NHS Confederation's chief executive, Philip Hunt, is to become a Labour working peer in the House of Lords. He will remain with the organisation until a successor is found.

Poverty at root of ethnic inequalities in health: People from Pakistan and Bangladesh living in Britain are 50% more likely to have ill health than white people, with people from the Caribbean 30% more likely. *The Health of Britain's Ethnic Minorities*, a report from the Policy Studies Institute, says that the differences in health are linked to poverty.

Tumour gene identified: Researchers have identified the TSC1 gene, mutations in which cause some forms of tuberous sclerosis, a genetic condition occurring in about 1 in 6000 people and affecting the skin and nervous system (*Science* 1997;277:805-8). A second tuberous sclerosis gene, TSC2, was identified in 1993.

Numbers of hospital doctors rise: Department of Health figures for England show that on average the number of consultants has increased by 3.4% and of junior doctors by 2.6% each year between 1986 and 1996. Much of the increase has been among women.

Clinical directors feel undervalued: A survey of 700 clinical directors in Britain by the British Association of Medical Managers found that almost 60% felt undervalued for their management contribution.

Experimental angina treatment rejected by the FDA

Deborah Josefson, *San Francisco*

An advisory committee of the Food and Drug Administration has recommended rejecting transmyocardial revascularisation as a treatment for angina. Currently an experimental treatment of last resort, the two hour procedure entails drilling small holes by laser into the heart in the hope that revascularisation of the myocardium will occur.

PLC systems, manufacturer of the laser used in transmyocardial revascularisation, had applied for the Food and Drug Administration's approval of the device and the procedure itself. Dr Mahmood Mirhoseini of St Luke's Medical Center in Milwaukee, Wisconsin, pioneered the treatment in an effort to provide an alternative method of myocardial perfusion in patients with ischaemic heart and coronary artery disease. It was developed after several investigators showed that reptiles and some fish achieve myocardial perfusion through direct diffusion of oxygen rich blood from the ventricular cavity into the surrounding cardiac muscle. Researchers believed that by surgically mimicking the reptilian circulation they might be able to augment conventional coronary artery blood flow and thus bypass diseased vessels.

Many people with end stage coronary artery disease do not respond to or are not suitable candidates for conventional

treatment such as angioplasty and coronary artery bypass grafting. Patients with diffuse disease, inaccessible or small vessels, unreachable plaques, or complicating systemic diseases may fall into this group. So far 198 such patients have undergone the procedure, 65% of them reporting significant relief from angina six months post-operatively compared with 10% of a medically treated control group. Moreover, nuclear perfusion scans of the heart showed greater blood flow in the experimental group.

Promising results

Despite such promising clinical results, the advisory panel of the Food and Drug Administration voted overwhelmingly to reject the technique. Dr Robert Califf, one of the panel's members, noted that the follow up time was insufficient and that patients who had switched from the medical arm of the study to the revascularisation arm had an increased mortality, with 66% of the deaths in the trial belonging to this group. However, this group of patients may have been more ill and switched because they were not benefiting from medical treatment.

Proponents of the technique point to the significant symptomatic relief experienced by patients, often beginning immediately after the procedure. They

also note that these patients have few options since most of their conditions are already refractory to medical and surgical treatment. Operation and recovery times are also less than those of coronary artery bypass grafting and therefore less taxing on the patient.

Advocates further believe that the laser channels mature into blood vessels or serve as "sinusoids," a river-like meshwork into which blood flows. But there is no evidence that this occurs. In fact, several experiments in animals and a handful of necropsy examinations show that the opposite is the case, raising the possibility that any benefits seen with transmyocardial revascularisation are due to a placebo effect.

Dr Peter Fisher, a pathologist at Columbia Presbyterian Medical Center in New York, has examined postmortem hearts of patients who had had the treatment and reviewed histological samples from animal experiments. He has found that invariably the laser channels are occluded by scarring and granulation tissue. "The mode of action is certainly not due to angiogenic neovascularisation. More likely, since the pain relief is immediate, it may be due to the anaesthesia of surgery or the excision of nerve fibres intraoperatively," Dr Fisher said.

He further speculated that since the patients have less angina they may be able to work through their pain and eventually develop better perfusion in a manner similar to patients with peripheral vascular disease and intermittent claudication. Dr concluded that the procedure seems to work but that no one knows why.

The advisory panel indicated that symptomatic relief in itself did not justify approval of the procedure since several drugs in the past provided relief but were later associated with increased mortality. Dr Ronald Weintraub, who is a member of the panel and from Harvard Medical School, voted for approval and worried that it would be unethical to withhold treatment to patients with limited options. "We are dealing with patients who are at the end of their rope. I don't think it's right to withhold potential therapy," he said. The Food and Drug Administration is not bound by its advisory committee findings but often follows them. □

Not all coronary artery disease responds to conventional treatment

Health professionals can prevent mental health problems

Jacqui Wise, *BMJ*

People at high risk of developing mental health problems can be identified and offered effective interventions, says a new systematic review of the evidence.

The latest report from the NHS Centre for Reviews and Dissemination at the University of York says that primary health-care professionals are well placed to identify people who are vulnerable to mental health problems (*Effective Healthcare* 1997;3:3). Poverty, bereavement, divorce, and unemployment can put people at risk of developing anxiety or depression (see box).

Socially disadvantaged children are at higher risk of mental health problems in childhood and later life, but several social interventions—for example, high quality preschool and nursery education—have been shown to work. Children showing behavioural problems in school or at home can benefit from school based interventions and parent training programmes. Emotional support and cognitive skills training can be used effectively with children after the death of a parent or for children of separating parents.

Social support, problem solving, and cognitive behavioural therapy can help unemployed people, the report says. A UK trial recently showed that group cognitive behavioural therapy training can increase general mental health in longer term unemployed professionals. It

suggests that there should be more proactive intervention. For example, large scale redundancies in an area should trigger action by local health authorities and social agencies.

Respite care and some psychosocial interventions can help carers, who may experience high levels of strain that are often unrecognised. Home based social support during pregnancy for women in disadvantaged communities can reduce the risk of postnatal depression.

However, there is little evidence that generic counselling provided by itself is effective, and more attention needs to be given to the content and effectiveness of specific forms of counselling and the skills of counsellors before this approach is extended too widely. But the report calls for improved access to services that provide cognitive behavioural therapy.

It says that primary healthcare teams should be aware of local services in order to be able to "signpost" people to other sources of intervention and information, including self help and user groups and the voluntary sector. The report states: "These preventative strategies should reduce future mental illness and other mental health problems but will increase further the pressures on primary health care, mental health professionals, and those working in related fields." □

Some characteristics of people at high risk of developing mental health problems

Children who are:

- Living in poverty
- Showing behavioural difficulties
- Experiencing parental separation and divorce
- Within families experiencing bereavement

Adults who are:

- Undergoing divorce or separation
- Unemployed
- At risk of depression in pregnancy
- Experiencing bereavement
- Long term carers of people who are highly dependent

Spectators at a nuclear bomb test in April 1955

Nuclear test fallout linked to cancer risk

Norra Macready, *California*

Nuclear tests conducted by the United States government in the 1950s and 1960s exposed about 160 million people to fallout from radioactive iodine, raising their risk of thyroid cancer, officials of the National Cancer Institute admitted last week.

Dr Richard Klausner, director of the National Cancer Institute, said 30% of the expected cancers have already been diagnosed. Ninety tests were conducted between 1951 and 1962 at an atomic test site in Nevada. Because the fallout entered the atmosphere, virtually everyone in the United States would have received some exposure.

In general, residents of western states to the north and east of the test site were exposed to the highest doses of radiation. Dr Klausner said that those who were children at the time of the tests were at the highest risk of developing thyroid cancer because the radioactive iodine fell on pasture lands, where it was ingested by goats and cows and concentrated in their milk. Children, particularly those aged between 3 months and 5 years, were most likely to be affected because they drink more milk than adults and have smaller thyroids. It is estimated that this age group received

between three and seven times the average dose of the rest of the population.

Congress ordered the government in 1982 to study the effect of radioactive fallout from the Nevada tests. The results, however, have only just come to light. At a sometimes acrimonious press conference last week, Dr Klausner maintained that the long delay in publicising the results was due to the complexity of the analyses required to make sense of the information. He conceded that release of the data "could have gone faster," but insisted that there had been no attempt at suppression, saying that institute scientists wanted to recalculate and double check their figures before making them public.

When pressed, Dr Klausner also admitted that, although iodine-131 concentrates in the thyroid, it can travel to other organs and cross the placenta, where it may affect the ovaries of a female fetus. Nevertheless, he said that there were not yet enough data to warrant a mass screening programme, while adding that he could not rule out the possibility that people who were exposed as children might have a heightened risk of cancer of the thyroid or other organs. He recommended that worried individuals discuss their concerns with their doctors and undergo regular thyroid examinations. □

A 1000 page report will be released on 1 October on the internet (rex.nci.nih.gov).

Asthma drug linked with Churg-Strauss syndrome

Deborah Josefson, *San Francisco*

The Food and Drug Administration in the United States has warned that zafirlukast (Accolate), a new asthma drug, may be associated with the Churg-Strauss syndrome—a rare and often fatal multisystem vasculitis. The warning was issued after six patients taking the drug developed the syndrome.

Zafirlukast is a leukotriene inhibitor—the first of a new class of non-steroidal anti-inflammatory agents approved in the United States for prophylaxis against asthma. It has been on the market there since September 1996 and is available in several European countries. The drug is expected to be licensed in Britain by the end of the year.

Leukotrienes belong to a family of inflammatory mediators. They have been implicated in various inflammatory diseases including asthma, rheumatoid arthritis, allergic rhinitis, psoriasis, and inflammatory bowel disease. Leukotrienes modulate various immune and inflammatory responses—enhancing mucus

secretion, increasing vascular permeability, and inducing smooth muscle contraction.

Hypertrophy of bronchial smooth muscle, plugging of airways with mucus, and inflamed and hyperreactive airways are hallmarks of asthma. In attacking a central mediator of these asthmatic manifestations, leukotriene inhibitors offer a new approach to the treatment of and prophylaxis against asthma. Some respiratory specialists believe that leukotriene inhibitors may reduce the need for steroids and bronchodilators in patients with asthma.

The Churg-Strauss syndrome is an allergic granulomatous vasculitis affecting small and medium sized arteries. It has a predilection for the lungs and may itself trigger asthma. It often presents with flu-like symptoms such as fevers, myalgia, headaches, and weight loss. Like asthma, it can be treated with steroids. More severe cases of the disease are treated with immunosuppressive agents such

as cyclophosphamide.

All of the reported cases of the Churg-Strauss syndrome in patients taking zafirlukast occurred when the doses of steroids for asthma were being tapered. The Food and Drug Administration has stated that there is no definite proof of a cause and effect relation between the syndrome and zafirlukast at present, and because of the rarity of the association it does not recommend that patients discontinue taking the drug without first consulting their doctor.

The Food and Drug Administration stated that on the basis of current information “the agency continues to believe that the benefits of this drug outweigh any of its known potential risks.” A spokesman for the manufacturer, Zeneca, said that the company did not believe that there was a causal relation between Accolate and the Churg-Strauss syndrome. However, it is adding a warning to the drug labels and has issued a letter to doctors about the possible association between the syndrome and the drug. Doctors are advised to monitor closely patients who are taking the drug and whose doses of oral steroids are being tapered concomitantly. □

Heart attacks linked to pollution

Jacqui Wise, *BMJ*

One in 50 heart attacks treated in London hospitals may be triggered by outdoor air pollution, according to a seven year survey. If this was applied across Britain it would mean that up to 6000 heart attacks a year could potentially be avoided if there was better control of exhaust emissions.

Researchers from St George's Hospital Medical School examined 373 556 admissions to London hospitals for circulatory diseases between 1987 and 1994 (*Occupational and Environmental Medicine* 1997;54:535-40). These were compared against daily measurements of ozone, nitrogen dioxide, sulphur dioxide, carbon monoxide, and black smoke. Other potential contributory factors such as temperature, humidity, the day of the week, and the influenza epidemic of 1989 were also taken into account.

The researchers found that on average there were 145 admissions a day for circulatory diseases but that the number of admissions increased markedly on the days after a surge in the pollution counts for everything except ozone. All the other pollutants were associated strongly with an increase in acute myocardial infarction even after the weather and the other risk factors were allowed for. Less consistent but still significant associations were found between black smoke and angina and nitrogen dioxide and arrhythmia.

Carbon monoxide emissions are a particular cause of concern, say the authors, because of the way in which the pollutant compromises the transport of oxygen around the body. This could strain an already susceptible heart during any form of exertion.

They write: “Biologically plausible mechanisms have been advanced by which emissions, mainly from motor vehicles, might trigger circulatory disorders. Our results strengthen the case for the existence of a causal link with myocardial infarction.” □

Canadians sue over hepatitis C infection

David Spurgeon, *Quebec*

A group of people who became infected with the hepatitis C virus through Canada's national blood supply have launched a class action lawsuit against the Canadian Red Cross Society, the federal government, and eight provinces.

The United States began screening blood for the hepatitis C virus in 1986, but Canada did not start until 1990 because the test was considered to be too expensive—around \$C10m (£4m, \$7m) a year. The class action lawsuit is estimated to cost around \$C3.5bn.

The action calls for financial compensation similar to that granted to 1000 Canadians who became infected with HIV after blood transfusions and who

Around 12 000 Canadians have developed hepatitis C from blood

have received about \$C30 000 a year since 1989. So far, no compensation has been offered to the estimated 12 000 people who have developed hepatitis C.

However, two days before the announcement of the class action suit the new federal health minister, Allan Rock, indicated that he was willing to consider

the issue. Last year his Liberal party turned down a similar request for compensation.

Timothy McClellmont, executive director of the Hepatitis C Society of Canada, said: “Everyone would prefer achieving compensation through the government rather than the courts.” □

Chinese clamp down on hospital overcharging

Richard Tomlinson, *Beijing*

The Chinese government has ordered Beijing's 600 hospitals and clinics to stop overcharging patients for unnecessary drugs and expensive examinations.

The hospitals have been set an October deadline in an attempt to limit the rapidly rising costs of medical treatment, a source of much complaint among patients. Needless prescription of drugs by doctors has also been wasting valuable resources, said the ministry of public health.

The problem stems from the cash strapped nature of most hospitals. In theory, prices in state hospitals for routine clinical consultations and operations are fixed extremely low—under 40 p (65 cents) for a consultation and £6 for an appendectomy. Thus hospitals and clinics try to compensate for this by prescribing expensive drugs and conducting expensive examinations using new and sophisticated

equipment. Separate fees are also levied for all ancillary services, such as the use of a bed, electricity, room cleaning, and any hospital food.

A recent ministry of public health survey of 210 000 people showed that more than half of those who became ill did not bother to seek treatment because the costs were too high. Healthcare costs are growing by 30% a year on average across the country.

Hospitals have been told to cut charges for examinations using "special medical facilities" by 10%. Beijing residents with incomes below the official poverty line and childless elderly residents should be given discounts of 20-50% for examinations and operations. The new edict also specifies that 10% of hospital earnings from clinical consultations are to be set aside to fund medical research. However, it is unclear how these reg-

Most Beijing hospitals are short of money

ulations will be enforced.

The central government has a vested interest in reining in healthcare costs because many Beijing residents and pensioners are still attached to state "work units" which must reimburse a large part of their employees' medical costs. The people most at risk, however, are those working for decrepit state enterprises that can no longer afford to pro-

vide the so called "iron rice bowl" social benefits, such as free health care and education. Medical insurance schemes are still at an early stage of introduction.

The Beijing reforms follow similar measures taken by Shanghai three years ago. That pilot project claims to have saved more than 3bn yuan (£250m), according to the official newspaper, the *China Daily*. □

United States budget supports child health

Fred B Charatan, *Florida*

Healthcare coverage for children in the United States is to expand under the new budget endorsed by congress last week after lengthy negotiations. A new programme costing \$24bn (£15bn) over five years will finance medical care for children without health insurance.

Individual states will decide what health benefits to provide, but the services must be similar to those in government or private business and will include immunisation programmes and regular check up examinations. They will also decide whether the coverage will be provided through enhanced Medicaid funding, state health insurance programmes, direct services, or some combination of these.

However, the congressional budget office earlier estimated that the new programme would

cover fewer than 2.5 million of the nation's 10 million uninsured children. In welcoming the new programme, Dr Robert Hannemann, president of the American Academy of Pediatrics, said: "The challenge now lies at the state level, where doctors must work to make sure that children receive the full benefits of the bipartisan budget agreement."

The bill also places greater emphasis on prevention, with \$4bn for Medicare—the health care programme for elderly and disabled people—to cover mammography, cervical smear testing, and screening for colon cancer, prostatic cancer, and osteoporosis. The budget bill will also pay for patients with diabetes to get education and counselling about diet and lifestyle.

Other new options for Medicare beneficiaries include the much criticised tax free medical savings accounts and private health plans that are owned and operated by doctors and hospitals rather than by insurance companies.

The budget bill falls short of

the widespread reforms of Medicare proposed by President Bill Clinton in 1994 and of the cap on spending called for last year. Three controversial proposals were ditched: increasing Medicare premiums for higher income beneficiaries, raising the eligible age from 65 to 67, and imposing a charge of \$5 a visit for home visits. But the bill creates a new federal advisory commission to study how Medicare can avoid a financial crisis when people born in the postwar baby boom become eligible for the programme after 2010.

Horace B Deets, executive director of the American Association for Retired Persons, said that the Medicare package was "a victory for all Americans and takes Medicare into the 21st century."

But Dr Percy Wootton, president of the American Medical Association, said: "Beyond the major benefit conferred by expanding healthcare coverage for children, this is a difficult agreement that has to be viewed as only a tentative first step toward preserving Medicare." □

Call for inquiry into CJD cluster

John Warden,
parliamentary correspondent, BMJ

The new chairman of the Commons health select committee, Labour MP David Hinchliffe, has asked the government to set up a judicial inquiry into the issue of bovine spongiform encephalopathy (BSE) in cattle and a possible link with Creutzfeldt-Jakob disease (CJD) in humans.

The inquiry would also look at why Ashford in Kent has become associated with a handful of deaths from CJD. Mrs Sue Carey, who died in March aged 36, has now been confirmed to have had new variant CJD. Mrs Carey was living on a farm at Mersham, Kent, when the first case of BSE in cattle was identified nearby in 1985. A rendering plant in the area has also been under suspicion for spreading effluent, including boiled cattle remains.

There are now 21 definite and probable cases of new variant CJD, of whom 20 have died. □

A challenge to produce harmony out of conflict

Dr John Chisholm, the new chairman of the BMA's General Medical Services Committee, won the leadership race decisively at last month's election and was greeted with a standing ovation. During the next year he may reflect wistfully on that moment of unity. Hilary Bower reports

Dr Chisholm is said to have a "razor sharp" mind

John Chisholm is a flautist and thus skilled at turning hot air into harmony. He is also a conductor, adept at reconciling potential cacophony, and a chorister used to melodious teamwork. He may need all these skills and more to coax agreement from the General Medical Services Committee, his hospital colleagues, and the government this year.

No stranger to the opinionated world of medical politics, 47 year old Dr Chisholm has been on the GP committee of the BMA for 20 years, as well as being joint deputy to the retiring chairman, Ian Bogle, since 1991. Now a GP in Twyford, Berkshire, he was educated at Clifton College, Cambridge University, and Westminster Medical School and is said to have a "razor sharp" mind and elephantine memory, both of which have been put to good use in developing the agenda pursued by the negotiating team in recent years.

Top of his priority list now, says Dr Chisholm, are the ever worsening recruitment and retention situation in general practice and its inextricably linked companion—pay. These are closely followed by the need

■ *"Professional unity ... is essential to maintain the influence of GPs in the next decade"*

to maintain unity among the profession and its representative bodies and to ensure quality in general practice. Pay and recruitment in general practice is in "a parlous state," he says. "The comparability differential is getting worse; morale in general practice is not improving; workforce figures are appalling; GP workload, intensity, and stress are all increasing. Something must be done urgently to counter these things."

But while he believes that

GPs deserve a "stonking" pay rise, he is also determined that the public should get reassurance of a quality general practice in return, by means of collaborative initiatives such as the General Medical Council's new performance procedures and planned reaccreditation schemes. Indeed, the need to work more collaboratively is a constant thread in Dr Chisholm's plans.

"As much as possible I want to get people working cooperatively with each other and facing in the same direction. We gain strength by networking and cooperating. We have to work together with the Royal College of General Practitioners and with all the organisations in general practice like the National Association of Fundholding Practices, the National Association of Commissioning GPs, the Overseas Doctors Association, the Dispensing Doctors Association, the Small Practices Association, the National Association of Non Principals. And we have to work together within the BMA—with the consultants, juniors, public health, academics, and so on."

Ironically, however, it is on this issue of professional unity that Dr Chisholm is likely to meet his first major challenges. He and the negotiating team are already on a collision course with consultants—for example, over the nature of this year's joint evidence to the pay review body. Against a background of barely healed scars caused by last year's pay battle—when the GP committee persuaded the BMA to present what many perceived as a ludicrous 58.3% pay demand—Dr Chisholm says that he is "absolutely determined" to tell the review body that general

practice needs a greater pay award than other crafts this year. Traditionally, this is only done with the support of other BMA groups, whose response so far has been decidedly cool. But despite his plea for unity, Dr Chisholm seems unwilling to demur for its sake. "My wish is to move forward as much as possible by consensus, but there will be occasions when I and my negotiators have to cause ill feeling and if this is one of them, so be it," he says.

Pay is not the only professional flashpoint on the horizon. Dr Chisholm's ability to "conduct" the chorus of conflicting views within the GMSC itself could be sorely tested over the next few months as negotiators thrash out the new regulations needed to govern GP participation in primary care pilot studies due to start on 1 November.

The pilot studies, which test new contractual ways of delivering general practice, will split family doctors into so called part II GPs, who remain independent contractors under the NHS Act, and part I GPs, who will become employees.

Potential conflict

Some predict that competition between the two groups will make it impossible for the GMSC to represent both. Dr Chisholm admits that there is ever increasing potential for conflicting interests, but he rejects the suggestion that the current GMSC and local medical committee structure should restrict its interests. "The GMSC is not some cosy club for part II independent contractor principals. Our job is to look after all of them, whether they are in part I or part II, salaried or independent contractors, working in career posts, non-principals or registrars.

"Professional unity and the maintenance of our representative structures are absolutely essential to maintain the influence of GPs during the next decade. If we keep our heads and think strategically, the problems that could supervene from different interests will not." What must be avoided at all costs, he adds, is a repeat of the fundholding debacle of the early 1990s, when the total opposition of the BMA and GMSC to the scheme relegated them to the sidelines and allowed the government to "divide and rule." Indeed, the negotiating team is now in the curious position of trying to protect the position of current fundholders under threat from planned government changes to the scheme.

GP pay and conditions are not the only tune in Dr Chisholm's repertoire. He is also keen to extend the voice of the GMSC far more widely on issues such as social equity, ethics, and public health. But only time will tell whether he can produce something resembling harmony from the diverse elements in his new band. □