BMA's current rejection of merged authorities monitoring fundholders because they are "in effect, competing purchasers"⁸ does not augur well. Nor does the anxiety among general practitioners and family health services authorities that the new mergers will swamp the interests of primary care with the concerns of hospital services (an anxiety sometimes matched by hospitals' insecurity that health commissions will become too immersed in primary care). We will need much careful work to build the necessary trust between these competing and mutually suspicious local forces if we are to see the genuinely integrated primary and secondary services that the bill intends.

The third set of tensions is between politically determined demand and scientifically founded evidence. There are often strongly differing views about the extent to which a particular service should be available. Previously it was easy—doctors knew best. Recently, however, the situation has changed as purchasers, providers, and other professionals and practitioners—not to mention the pharmaceutical industry, politicians, press, pressure groups, public, and patients—are taking a much greater role in shaping policy. Moreover, it is becoming increasingly clear that they are right to question the doctors because there is a dearth of evidence of the effectiveness, let alone cost effectiveness, of most medical activity.⁹

Yet all the parties in such debates base most of their views on beliefs, not evidence. Given that under the new legislation many of the protagonists will, as described above, gain more scope to pursue their own interests, there is obvious potential

for adding to the strain between them. Perhaps the key to the bill's success will lie in the increasing commitment to health services research and development, to continuing professional education, to evidence based medicine,¹⁰ and to more open access to knowledge. The more the NHS invests in increasing its knowledge base the less are the political debates likely to split it asunder. In short, if the new legislation is to work despite the underlying tensions it will need to be very carefully managed. Coupled with greater trust, better communication, and above all a genuine commitment to knowledge based decisions, it could set an international example for managed care organisations. The NHS cannot afford to get this wrong.

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Psychological care of medical patients

Time to recognise the need and provide services

People with appreciable physical illness have at least twice the rate of psychiatric disorder found in the general population, with a concomitant increase in clinically important disorders that just fail to meet standard diagnostic criteria. The main problems are mood disorder,¹⁻³ cognitive impairment,^{4,5} substance misuse,^{6,7} and abnormal illness behaviour or somatisation.^{8,9} These disorders are clinically and personally important: they impair quality of life; reduce the ability to adhere to, or benefit from, treatment for medical conditions; and are associated with a poor outcome of treatment for physical illness. Episodes of medical care are more complex and costly in those whose physical disorder is accompanied by psychiatric comorbidity.¹⁰

Effective treatments exist for psychiatric disorder in physically ill people, which are remarkably cheap for the benefits they provide. In fact, the costs of providing psychiatric treatment in a medical setting may be more than met by the savings that result from reductions in inappropriate medical investigation and treatment—the so called cost offset effect.¹¹

Unfortunately, few hospitals arrange formal services to meet the psychological needs of their patients. Instead they rely on a mixture of informal provision in some areas and neglect in others. This approach may be unsustainable in future. Existing working relationships between psychiatrists and general hospital doctors are under strain as the health service reforms have placed most mental health services in different trusts from general hospitals. The emphasis on community care in psychiatry means that psychiatrists spend less of their working week in hospitals, so the opportunities for informal contact with colleagues are diminished. Until

recent years many people with chronic mental illness and coexisting physical illness could be treated in psychiatric hospitals. Now, pressure on beds in both psychiatry and general medicine makes the already difficult task of caring for patients with coexisting mental and physical illness harder. At the same time, the growth of consumerism in medicine and heightened public awareness of the psychological aspects of physical illness add to the demand for relevant services.

Daunting agenda

In response to the perceived gap between the needs for, and availability of, psychiatric services in general hospitals the Royal College of Psychiatrists and the Royal College of Physicians have jointly published a report on the psychological care of medical patients.¹² This is not a bland appeal to the principles of holistic care but a bench manual for those who plan and deliver services. The working group has tackled many practical aspects of the psychological care of medical patients, and the agenda it sets the profession is daunting.

Physicians, surgeons, and general nurses need the skills to identify psychological problems in their patients, to offer appropriate psychological care, and to know when and how to refer for psychiatric help. When a referral is made it needs to be picked up by a psychiatric service that understands the complexity of physical and psychiatric comorbidity and can deliver appropriate treatments that are accessible and acceptable to the referring agent, the other staff working in the general hospital, and the patient.

Fortunately, the working group's report includes sections

on defining and recognising psychological problems and outlines the main approaches to treatment. There are sections on different models of liaison psychiatry services and how to arrange for their purchase (liaison psychiatry is the subspecialty of psychiatry concerned with clinical service, teaching, and research in non-psychiatric health care settings).¹³

Training for specialists and non-specialists has a separate section, although there is unfortunately nothing on the relevance of liaison psychiatry to undergraduate education. The refocusing of undergraduate medical education by the General Medical Council¹⁴ has highlighted the need for training in those aspects of psychiatric practice required most urgently by newly qualified house staff, and most of these are recognisably within the remit of the working group's report.

There is a welcome guide for purchasers, many of whom will not think about these issues unless carefully briefed to do so. The advice is forthright: acute services in general hospitals should be purchased only where an adequate liaison service is included, and the cost of the liaison psychiatry service should be included within the costs of each medical service. Quality of service and expediency are among the reasons for arranging integrated physical and psychiatric care. There is also a financial argument. One study from the United States showed that an orthopaedic liaison psychiatry service paid for itself by reducing lengths of stay by an average of two days, saving more than \$250 000 of the inpatient costs of treating 452 patients.¹⁵

For those who want the planning of services to be evidence based, the authors have included an extensive bibliography to support their conclusions and recommendations. This important report deserves to be widely read and acted on by

those who commission care for physically ill patients and those who provide it.

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Human tissue: ethical and legal issues

The report from the Nuffield Council on Bioethics provides a coherent legal and ethical approach

Advances in biotechnology and increasing public concern about the uses to which human tissue may, can, or should be put make the recent report of the Nuffield Council on Bioethics timely and important.¹ It provides a lucid, rigorous, and balanced view of the dilemmas that the potential scientific uses of human tissue pose for ethics and the law. The report is wide in its approach, dealing with everything from physical and intellectual property rights to confidentiality, compensation, and capacity.

In its coverage of ethics the report takes an imaginative, although not unarguable, approach which effectively eschews strict adherence to more traditional approaches (such as utilitarianism), concentrating instead on two fundamental principles—the avoidance and limitation of injury and (a secondary consideration) matters of consent. This approach seeks to provide a form of practical ethics that the more standard theories have, in the view of the working party, failed to achieve. The working party therefore starts from a permissive rather than an inherently restrictive perspective, seeking harmony and balance rather than to choose one ideology over another. Even though argument with this perspective is possible, it provides an unusually cohesive basis from which to stimulate debate, and if for no other reason than this it is to be welcomed.

One of the report's most important conclusions is that the intention behind the use of human tissue should play an

important part in the ethics and lawfulness of this use. Although avoiding and limiting injury is regarded as a "basic requirement," much of the report necessarily concerns two other concepts—consent and property. In the discussion of consent special attention is paid to children and to people who are legally incompetent. Unfortunately, the sections concerning children refer exclusively to the position in English law (which may have important differences from Scottish law), and certainly the conclusions drawn are not necessarily applicable to those beyond the jurisdiction of English common law and courts. However, the principles that emerge—that children should be encouraged to participate in decision making, that any sign of refusal should be taken seriously, and that parents (or equivalent) should be deemed capable of consenting as proxies—are protective of the interests at stake, even if the lawfulness of proxy consent by parents is controversial.

With respect to mentally incapacitated adults the report notes that consent is effectively unobtainable in current law. None the less, pragmatic ethics might suggest that a way round this should be found, and this, the report suggests, might be achieved by invoking the public interest, always provided that the basic ethical principle of avoiding harm is borne in mind and that the uses to which the tissue is to be put are ethical. This would give mentally incapacitated people protection equivalent to that enjoyed by children