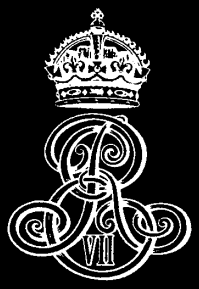
EIGHTY-FIVE NOT OUT

Essays to honour Sir George Godber

EDITED BY STEPHEN LOCK



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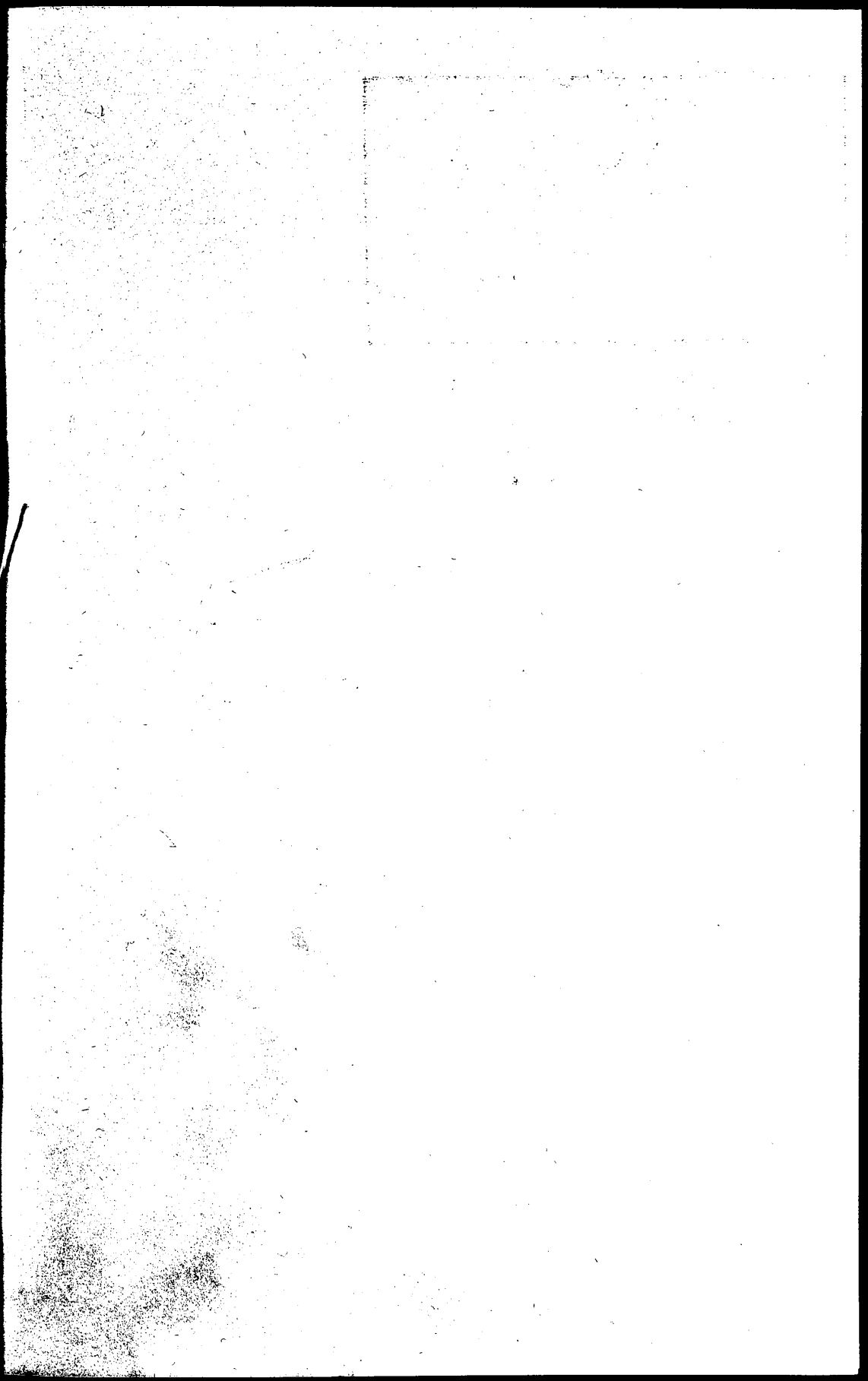

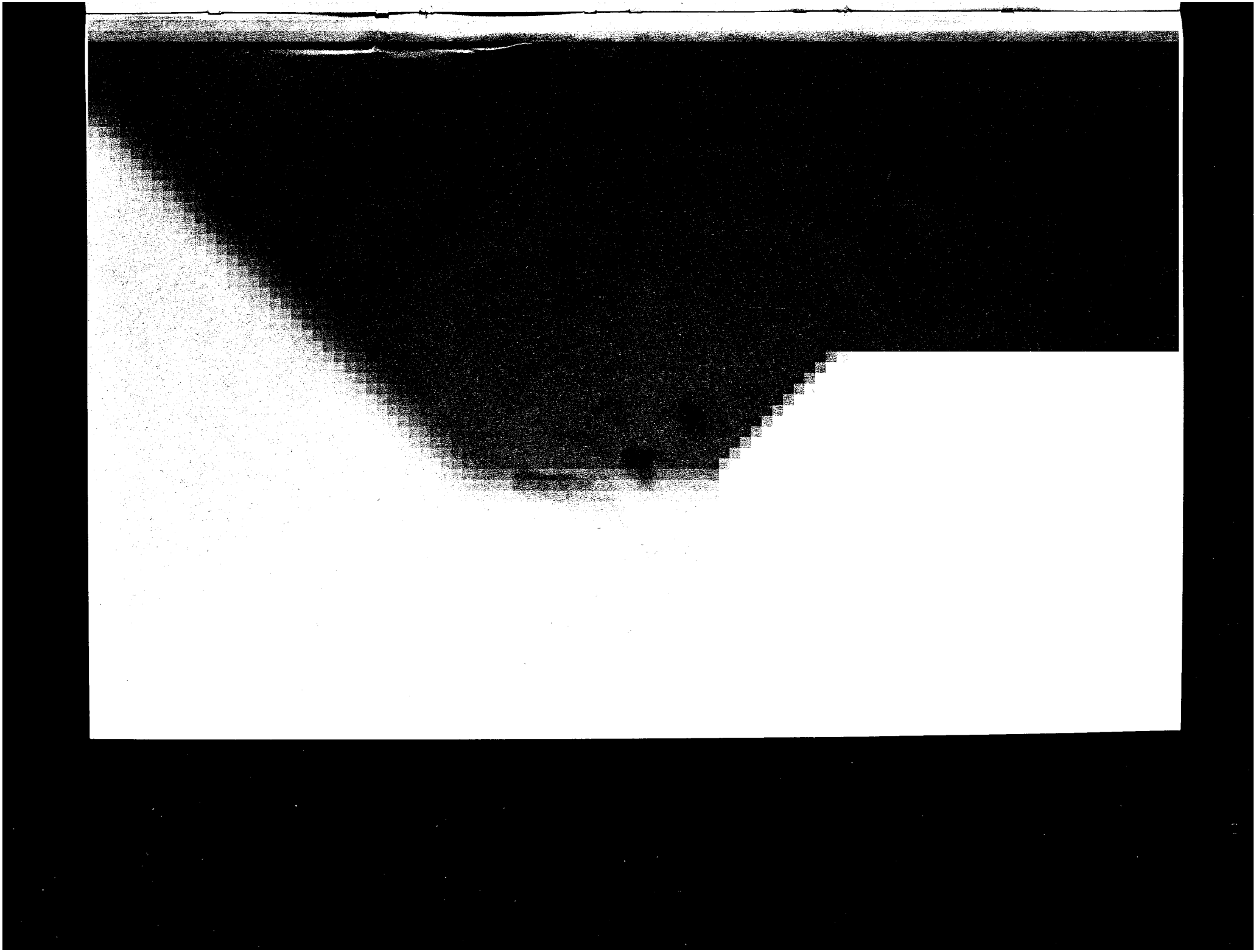

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Preface

ROBERT MAXWELL

The idea for this seminar to mark Sir George Godber's 85th birthday stemmed from Professor Rudolf Klein and Dr Stephen Lock, both of whom are expert judges of timing. All I had to do (with the full backing of the Fund's Management Committee) was to make it happen.

Sir George does not like any fuss. When he retired from the Department of Health in 1973, after a third of a century there, including thirteen years as Chief Medical Officer and ten years as Deputy Chief Medical Officer, he managed to slip away after a cup of tea, at the end of a working day. So I had to catch him by stealth. Fortunately what we wanted was compatible with his own inclinations. It was not to be a nostalgic celebration of the past, still less a eulogy of George himself.

The aim was to examine issues of substantial relevance to the present and future of the National Health Service, using the past to help, but not to constrain us.

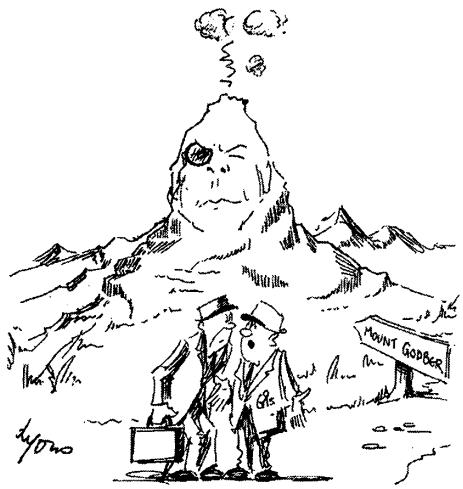
A number of short papers were commissioned. My job of organising the event was made much easier because virtually everyone accepted, the only refusals coming from a handful of people who had truly unavoidable prior commitments. The idea was to maximise discussion time, so people spoke only very briefly to their papers.

Some sixty people attended the seminar, held at the King's Fund College on 9 July, including Sir George himself, Lady Godber, and their three children. Those invited fell into three groups, though I encouraged people to decide for themselves into which of the three they fell. There were some of George's own friends and colleagues ('golden oldies'), like, for example, Sir Francis Avery Jones, Sir John Reid, Dr Julian Tudor Hart, and Dame Rosemary Rue. Then there were a substantial contingent of the current 'great and good,' headed by Dr Ken Calman, the current Chief Medical Officer.

Finally there was at least an equal number of 'young tigers', those who are likely to hold the future of the NHS in their hands. It was always characteristic of Sir George that he liked to hear what the young thought, and he still does. (Another of his characteristics, in my experience, is that he remains an omnivorous reader and keeps telling me – always accurately – what I ought already to have read, and have not yet got around to reading).

As always a book captures the formal contributions better, and, having listened to the recorded discussions, we decided that, excellent though these were, they would seem too disconnected in print to match the quality of the former, and hence would be better left out. Overall, self-evidently, it was a good day. What we shared was not only our respect for Sir George, and the monolithic contribution that he made to the NHS in his day (reflected, for example, in the Mt Godber cartoon below), but a passionate concern for the NHS.

At the end of the day nothing could have given me more pleasure than George's own comment that the seminar was the nicest compliment he has ever been paid. I hope that for a wider audience the book will add appropriately to that compliment by stimulating thought and helping to shape the future.



'... WHEN HE WAS SUPPOSED TO BE EXTINCT.'

Future directions for healthy public policy

JOHN ASHTON

The health and health needs of a population are dynamic phenomena. They depend on the population's structure and on its characteristics, as well as the endemic threats from the environment – whether communicable or otherwise – and their precursors such as poverty and lifestyle. They also depend on the capacity of a range of interventions – whether political, social, or technical – to make a difference and the social and cultural values and political will which would seek to do so.

In the second Duncan lecture delivered by Sir George Godber in Liverpool in 1984 in honour of the UK's first medical officer of health[1], Sir George reminds us that: 'it has been characteristic of the evolution of public health in Britain that most would show the way on protection of water suppliers, disposal of human wastes, condemnation and replacement of unfit housing, organisation of antenatal care, and preventive paediatrics. Then, having proved their point, they would pass on to others technically equipped and qualified, the full development of the programme.' In a robust defence against then current criticism, Sir George goes on to emphasise the major contribution made by medical officers of health in the development, establishment, and consolidation of the National Health Service.

Much has happened since 1984, and in many ways the NHS looks very different now than it did then; the task of innovation and change, however, remains the same. The Acheson report on the Public Health function in England, the Health Service Reforms, and the unveiling of a National Health Strategy have set the scene for a public health renaissance. The desire to get the balance right between a focus on populations and one on risk groups; between health promotion, primary, secondary, and tertiary care; and between self-care, public, private, and third-sector provision has arguably created an opportunity to stand back and take a clear

strategic view of where the greatest potential for health gains lies. At the same time it makes clear our continuing failure to address the issues surrounding poverty and various forms of deprivation and health, and the fact that we continue to try to squeeze a quart out of a pint pot.

FUTURE DIRECTIONS

What then are the future directions for healthy public policy? If we take the three objectives of a health strategy as being to protect and maintain health by keeping people well, getting people better, and looking after people by an optimal combination of self-help and the organised efforts of society, clearly certain key megatrends have dramatically changed the backcloth since 1948. These include the demographic transition and the greying of the population, the greening of the environment, and the recognition that the sanitary idea which drove the Victorian public health movement is ultimately a flawed one which needs to be rethought. I have argued elsewhere that the sanitary idea needs to be replaced by the ecological idea for the new public health (the need for reciprocal maintenance or looking after the things that look after us, whether these be the physical environment, our own bodies and souls, or our social networks of support)[2,3]. The relevant megatrends also include changes in endemic threats to health, with the virtual disappearance of infectious diseases in developed countries but the appearance of HIV and the dominance of non-communicable threats, including accidents and other conditions which should be largely avoidable until the fourth quartile of life.

These changes have taken place against a background of significant breakthroughs in knowledge, ranging from that concerning psychological and social dynamics to the capabilities of biomedical interventions to make a difference. Reshaping the optimal combination of self-help and the organised efforts of society to respond to this change is at least in part what lies behind the agonies of health services changes at the moment – and where the disciplines of public health have such an important part to play.

FRAMEWORK

Much of the framework for the development of this new public health has been articulated by the World Health Organisation in its documents relating to the strategy of Health for All by the Year 2000[4–8]. In particular, the Ottawa Charter has specifically placed the biomedical and technical contribution to public health within the wider context of healthy public policies in the many domains of everyday life and on the need for professionals to come off their pedestals, to work with each other in a multidisciplinary way, and to begin to regard the public as equal partners in the protection and promotion of health – professionals 'on tap' rather than 'on top.'[9] In recognising the contribution of the World Health Organisation in setting the scene for what is now required it is also worth remembering that the impulse which created the WHO in 1948 was borne out of consequences of the 1930's recession, the Second World War, and a desire to create world conditions which would prevent a recurrence. The present global crisis with the ecological, economic, communal, and social dimensions and their collective health impact – together with the apparent inadequacies of the United Nations and its agencies, including WHO, to provide an adequate response – demand urgent action if the new public health is to have any chance or to be more than rhetoric.

On a more national and parochial level, while to some extent public health has been successfully repositioning itself to respond to the new challenges, much reorientation still needs to be done if the task is to be tackled as effectively in the next 20 years as the public health pioneers, including Sir George, have done in the past. In particular, it is necessary to recognise that, while some may be called public health practitioners, all clinicians and staff in the National Health Service (and many in local government and beyond) are part of the public health mission. Our medical and public health schools and related institutions need to grasp this nettle urgently and ensure that there is a diffusion of skills and a real commitment to multidisciplinary working. The megatrends towards public participation and intersectoral working need to be reflected in the educational establishments response[10,11]. I hope that there are

signs that in implementing the General Medical Council's recommendations on undergraduate medical education this might at last be the case.

The global move towards simultaneous centralisation of specialist functions and decentralisation of generalist ones, together with the collapse of monolithic solutions in favour of multiple ones, are clearly having strong resonances in health systems, with reorientation away from general hospitals towards a variety of specialist units and health centres. In this, somebody needs essentially to take a population overview and to be responsible for doing the strategic knitting. Moreover, also in the light of the current review of the intermediate tier of the British National Health Service, it is worth referring again to Sir George's 1984 Duncan lecture[1] and his comments on the importance of regionally planned but locally managed services to provide an effective service.

In this short overview I have inevitably been selective. There has been little discussion of, for instance, the globalisation of threats to health or the need for globally synchronised responses to parallel the effective locally based public health movement of the past, or of the revival of commitment to the foreign ministry role of the director of public health: to ensure that, not only does the Health Service deliver its direct contribution to the health of the population, but that through partnerships with other sectors and agencies – and through health advocacy – the population's resources as a whole are mobilised for the benefit of the common-wealth. In this the media too have a central and rapidly growing role.

CONCLUSION

To summarise, the agenda for healthy public policy for the '90s and beyond is broad and encompasses not only the reorientation of training and research in institutions traditionally regarded as part of the health enterprise but many others besides. It must also encompass a genuine commitment to interdisciplinary and multisectoral working, where leadership may vary depending on the task in hand but where it is unlikely that public health practitioners will be shy about offering their contribution.

A final point on the vexed issue of equity and our failure to confront inequalities in health; to quote Sir George again: 'Equity in health care would not be equality; the worst off would need the most.'

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Future directions for healthy public policy

BARONESS JAY OF PADDINGTON

I would like to pick up something that Dr Ashton said about the developing importance of public health in the context of the new look at this in the '60s and '70s. The enduring truth, it seems to me, is that public health is based in politics with a small 'p', and, particularly in political philosophy, has developed even more intensely in the last decade at precisely the time when the new awareness that public health was an issue for policy came to the fore. I would like to illustrate this if I may, briefly and I hope controversially, to stimulate discussion of the *Health of the Nation* policy.

There is a real tension between some of the concerns which might be developed by the people here in this room and by the minister in the Department of Health and an underlying political philosophy which has lain behind much of the thinking of the Government over the last decade and particularly in the specific policies of some of its departments. I enormously welcomed, and indeed continue to welcome, the appearance of the *Health of the Nation* as a strategic document for developing all the policies that it embraces in public health. It was a very courageous and radical new move by the Department of Health to take on something of this kind and to move so pro-actively into preventive medicine and into partnerships with other agencies and the whole population. We are at the moment in the middle of a two week celebration of the anniversary of the *Health of the Nation* and when Dr Calman was at the recent NAHAT conference he cautioned us about the need to, as he described it, 'try harder and make special efforts to achieve the complex targets which are buried in the five key areas which you will all be familiar with.' I have to say that I was rather irritated with the pronouncement of the Secretary of State for Health when she announced that she was going to 'try harder' by walking up the stairs at her Department and would serve fruit and not biscuits at

office meetings. If we are going to grasp the *Health of the Nation's* principles in the way that they should be grasped, we have got to look at them slightly more seriously and fundamentally than that.

I was told yesterday (8 July 1993) at the Lords, in response to a question which I had asked, that the Government will be publishing a proper, first report on the *Health of the Nation* stating where we are on target for September. It is going to be very important to see what progress we have made on these precise targets which were set last July, and Baroness Cumberlege, the Health Minister who leads for Health in the Lords, did honestly reply that in her view for the majority of targets progress was not going as fast enough as had been hoped, and for some it had even gone backwards. But I'm afraid that I will continue to believe that this particular Government's political policy is bound to undermine the sincere attempts by Health Ministers and by health professionals to achieve a healthier nation for the next century. Interestingly, several relevant themes came out of the exchange that we had in the Lords. For example, Lord Rea, who is himself a general practitioner, again drew attention to the extraordinary fact that the relationship of poverty to inequalities in health is totally omitted from the *Health of the Nation*. I do not need to remind this audience, and especially the guest of honour, that the work of people like himself and of Sir Douglas Black and subsequent similar research still lies unused in many political offices in this country. And, continuing in the Lords yesterday, Lord Rea said that: 'if the health of the less well off in Britain could be brought up to the level of the better off, the targets in health of the nation would be achieved or over-achieved.'

HEALTH GAIN TARGETS

I recently attended another conference in London where another London GP was talking about health gain targets as they related to various local developments in the health of his nation. Speaking rather movingly and quite passionately, he said that for him the most important minister who was affecting his patients' health was not Mrs Bottomley, but the Chancellor of the Exchequer. All of you must have noticed that the professional magazines and the general

newspapers are now full of reports that, at this time of high unemployment, there has been the return of the 'poverty diseases' such as rickets, scabies and scurvy – all of them frankly almost unknown twenty years ago. High long-term unemployment also has another impact: on mental health. Moreover, there are still 50,000 low birth weight babies being born in this country, in spite of our immensely good obstetric, maternal, and paediatric services, and that is to do with poverty and not with the health service.

To look at the specific targets in the *Health of the Nation* the one place you see the tensions between the priorities of the Chancellor of the Exchequer of the Treasury and the public health priorities of health ministers most vividly is in tobacco. Under the targets in the *Health of the Nation*, coronary heart disease and stroke are major topics where there is an obvious concern to reduce death. The report, for example, talks about the need to reduce the prevalence of smoking to no more than 20% by the year 2000, and reduce the consumption of cigarettes by at least 40%. Yet there is no mention of the conflicts of policy because we get £7 billion in tax revenues from the tobacco industry. The Government does not feel able to implement some of the recommendations by its own advisers, such as banning tobacco advertising, and has recently endorsed an EC decision to increase expenditure on subsidising tobacco growing. It must be very frustrating for the health ministers and chief medical officer but there is a basic philosophical conflict there. Now, I am not saying that a Government of any other political colour faced with the Public Sector Borrowing Requirement as it is, would find it easy to turn its back on the revenues raised by the tobacco industry. But one still has to acknowledge real central philosophical and political tension which we need to resolve.

Sexual health is another key area in the *Health of the Nation*, one that I have been especially concerned with. Again, we seem to lack consistency of purpose, and this, I think, reflects ambivalence about the role of the state in promoting public health in what is an area of very intimate personal behaviour, in which people are clearly concerned and rightly concerned about the different moral, religious, and ethical values in our multi-cultural society, and the need to intervene on a public health basis. I have been working with Robert

Maxwell and the King's Fund College on the extremely complex topic of changing sexual behaviour in the population. We held a conference a year ago with people from very different backgrounds (not just health education or academic backgrounds) to think about how to intervene on the subject of HIV and AIDS. How can one persuade people to change their behaviour even when the great majority of people in this country understand the facts? We had a variety of conclusions, but one of the most fundamental was that most people do not see their sexual behaviour as anything to do with health. This is, of course, the problem that you have if you are trying to organise public policy.

Since last year, we have seen the publication by the Department of Health of an extremely good handbook detailing the local initiatives which need to be taken if we are going to make any impact not simply on HIV and AIDs, but also on the high-rate of teenage pregnancy, which is the highest in the industrial world. The authors put enormous emphasis on going way out beyond the health service to try to halve this rate by the year 2000.

SEX EDUCATION

One aspect where the *Health of the Nation* key put enormous emphasis on was the partnership with schools – yet there seems to be no way in which the health departments and the health ministers (whether locally or at national level) can bring pressure to bear on schools to do the appropriate things. In fact, it is even worse than that. Again you see an enormous tension, within the Government and with people's political philosophy, about what you can do as a school, what parents should be allowed to do, and what teachers should be able to do. Only at this time last year we had an extremely important, helpful handbook from the Department of Health on HIV, AIDS, and sexual health. Yet now we have the department of education cancelling its central grant to schools for health education advisers, and just this week in the Lords we had an amendment put down by the Department of Education Ministers taking HIV and AIDS out of the national curriculum (where it has been only since last August) and, at the same time, giving parents the right to opt

out of sex education. I think this is crazy. We know that 96% of parents want children to have sex education in schools, and we now have a new policy which says that they can remove them from these lessons. My concern is that precisely the children who are most vulnerable and who most need sex education in schools will be opted out.

CONCLUSION

If public health has a political basis you are bound to get tensions and conflicts unless someone takes the robust and energetic attitude which enables a consistent political philosophy to be reflected in consistent political actions. This is central to the whole concern about how we move forward on public health. We have got to try to see that those of us concerned about public health issues are allowed to develop them across the board and to develop our political philosophy as a priority which cannot be blown off course by all these different tensions about political expediency and different views about subjects not related directly to public health. Above all, however, I would like to see us all acknowledge that the health and the wealth of the national are inextricably linked.

The future of general practice

IONA HEATH

In our society the general practitioner is the guardian of the interface between illness and disease. This is the key role of general practice and its retention is essential for the future of general practice. Illness is what patients have on their way to see the doctor, and a disease is what they have on the way home. This is put much more elegantly by Arthur Kleinman:

> 'Illness complaints are what patients and their families bring to the practitioner . . . Disease, however, is what the practitioner creates in the recasting of illness in terms of theories of disorder. Disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice.'

All disease involves illness, but by no means all illness involves disease. Both the disease and the illness may be more or less serious. The role of the general practitioner is to make these distinctions and to diagnose disease, to refer serious treatable disease to specialist colleagues, to treat less serious disease, and to interpret and witness the suffering brought by illness.

Guardianship of the interface between illness and disease fulfils an essential social role. Much human suffering manifests itself as illness. By no means all of this fits our understanding of disease. The recognition of disease implies a biomedical model and, often, the availability of appropriate treatment. If illness is mistakenly identified as disease, society incurs the cost of treatment and the patient is at risk of iatrogenic damage. The guardian role underpins the well-recognised cost-effectiveness of British general practice. In societies where there is no guardian, there is a perceived need to create one.

REQUIREMENTS OF ROLE

The requirements of the role are partisanship, generalism, empathy, and words. The doctor undertaking it must be always, vehemently, on the side of patients, witnessing, and sometimes interpreting, their distress with unconditional positive regard. Only if the doctor acknowledges all forms of distress as legitimate and only if the doctor can listen and hear to the extent of being able to empathise, will the patient feel understood and able to trust. The meanings of illness, the threat, the fear, the suffering, and the endurance can be interpreted, ordered, and contained only if both doctors and patients can find and agree on the right words.

The role is difficult, challenging, and immensely rewarding. It is also poorly understood by those outside general practice. It is easily undermined by this misunderstanding, and this explains much of the current crisis for British general practice.

The guardian role must be central, or it will be lost. General practice feels itself to be in a state of crisis and I believe that this is because of the unprecedented levels of threat to this key role. General practitioners are being pulled in a mass of different directions while feeling themselves to be undervalued and underachieving in the most important aspects of their work. The government carries a lot of the responsibility for this situation.

The new contract showed little understanding of the nature of general practice. With its imposition and the almost simultaneous introduction of the purchaser/provider split as part of the NHS changes, general practitioners have been asked to take on a bewildering variety of new roles. There is a view among some politicians and managers that general practitioners could take on a considerable amount of work currently done by specialists in hospitals, so saving money. This could be done, but it might well be at the expense of the more central and fundamentally generalist role of guardian of the illness/disease interface – and this could prove very much more costly to society in the long run.

NEED FOR SUPPORT

To be fully effective the general practitioner must work across a very broad front and, because of this breadth, will always need specialist support. There must be ready access to a wide range of specialist knowledge and skills. Where this support is not available the general practitioner feels much more exposed and is much less able to work to the limits of his or her expertise. Again, this is likely to undermine the cost-effectiveness of the general practitioner.

The general practitioners of the generation preceding my own fought to establish general practice as a respected discipline in its own right. This was a tremendous achievement in the teeth of considerable opposition from our specialist colleagues. The struggle for recognition, however, may have taken its toll in an obsession with rigid standards at the expense of diversity. Similarly much general practice research has suffered through seeking the approbation of specialist colleagues in academic medicine. Again Kleinman puts this much more elegantly:

> 'Symptom scales and survey questionnaires and behavioral checklists quantify functional impairment and disability, rendering quality of life fungible. Yet about suffering they are silent. The thinned-out image of patients and families that perforce must emerge from such research is scientifically replicable but ontologically invalid; it has statistical, not epistemological, significance; it is a dangerous distortion.'

CONCLUSION

The undeniable achievement of general practice research has been the work on the subtle and intimate dynamics of the consultation. We need to bring the same degree of rigour and detailed sensitive observation to the stories our patients relate. These stories tell us about the beginning of illness and within that the beginning of disease. We will continue to need quantitative research, but the great strength of general practice in the future may be qualitative research, borrowing skills from ethnography, anthropology, and

biography. As David Metcalfe has said: 'rigorous qualitative methods which are needed to elucidate the "why" of situations described in quantitative terms.'

If we can achieve this we will have found the basis on which to reassert our belief in and our commitment to our key role as guardian of the illness/disease interface. We will have extended our own understanding, and we will be in a better position to share that understanding. We will have rediscovered our confidence in the future.

The future of primary care

JOHN HOWIE

As a background to preparing this paper, I read again Sir George Godber's William Pickles's lecture to the Royal College of General Practitioners in 1985, 'Change and Continuity.' I will start this short – but I hope not simplistic – comment on the future of primary care with a quotation from his lecture, and close it with another. The first quotation is: '[in 50 years] . . . my insistent impression is of change, but with continuity and evolutionary growth, rather than imposed reform.'

I will look forward at primary care under three headings: its content, its organisation, and its professionals. The first is about evolution, the second about revolution. The third is in the balance. The future depends on bringing the three together.

THE CONTENT

The content of primary care has a central core and two main interfaces, one with secondary care and one with self-care and social work. The Balint school made us make a formal commitment to recognising that consultations have an organic and a behavioural mix, and Stott's model of consultations has provided a practical aide-memoire for extending the vision of content into the four areas of the acute problem, the co-existing continuing health problem, health promotion, and the modification of help-seeking behaviour. We understand better how to integrate these components and our undergraduate teaching and postgraduate training help us to define and prioritise our patients' needs, wants, and expectations better. I see no obvious need for this vision of core content to change much in the decade to come – and, even if molecular biology fulfils its potential to write new agendas that are beyond present imagination, these underlying principles seem likely to be robust enough to encompass them.

At the interfaces, however, change will gather pace. The sophistication and expensiveness of hospitals will alter the flow between primary and secondary care in both directions and, although this will not involve many patients at any one time for any one general practice team, the new demands and skills needed to meet them will need to be addressed. The interface with self-care will be better understood as we work more closely with social scientists, and the potential evolution of partnership between primary care and social work services is, for me, one of the most important areas of opportunity waiting to be grasped.

THE ORGANISATION

Within primary care, the evolution from the pre-Charter 'lock-up' surgery days to the modern health centre has been an astonishing change and exciting to be part of. Within many of our health centres much of the way health care is delivered has changed; in some others the processes of care are disappointingly static. The overwhelming evidence that a practice and primary care structure which leads to average face-to-face consultation times of around 5 minutes is less good than one where around 10 minutes is available now needs to be translated into practice. Without that, the delivery of 'quality' – defined in any reasonable way – will be limited, and the vision of primary care provision being centred on general practice teams will be put at risk of being substituted by alternative options. To match this evolution we need more involvement of nursing and other professionals. 'Cost-limiting' support for them, and attempting to downgrade their contracts and to administer their work from elsewhere than their 'team' base, seem wrong strategies which need urgent reconsideration.

At the 'macro' level, the jury is going to be out on fund-holding and the market culture for some time yet. Without doubt, fund-holding has unlocked the NHS status-quo and in a much needed way. But fund-holding mechanisms are inadequately scientific to become the basis of a structure as against an experiment. By the time they become acceptably founded, it is either possible or probable that different ways of achieving the same benefits will have

been found, and some of these will be more equitable from the patients' point-of-view and less devisive from the health professionals' standpoint.

THE PROFESSIONALS

The need to teach undergraduates medicine in the setting of general practice, and to train postgraduates who are to become principals, are issues agreed and implemented. Continuing education and re-accreditation are the issues of today and tomorrow – the second a theme requiring sensitive thinking lest the countable becomes an inappropriate proxy for defining goodness. Other health professionals have different training needs and there is scope for education in group management skills as well.

The immediate problem facing health professionals in primary care is that of job satisfaction and morale. It is impossible to summarise adequately in a paragraph the complex theoretical and practical issues, but yesterday's role uncertainty about whether to be a patient-centred (Balint) physician or an illness-centred diagnose-and-treat internist has been compounded by current additional choices. Failure to be a health promoting-target achiever leads to loss of income; becoming a supermarket administrator instead of a small businessman risks introducing a 'money-before-value' culture rather than the 'value-for-money' one it is easier to understand and defend. The interplay of these conflicts with the issues referred to under my headings of 'content' and 'organisation' spells 'stress.' Unresolved stress leads to poor patient care through less emotional rapport between patient and carer, and that correlates with burnout and early retirement from our professions at a level unimaginable a decade ago.

The problem is that those who are most comfortable with the market culture are having the time of their lives, are visibly happy, and are those the politicians meet and assume are normal. We ignore the wider reality at the peril of the future well-being of patient-centred primary care.

CONCLUSION

By definition, primary care will continue. How it will be structured, who will deliver it, and what it will contain is not self-evident. I believe that patient- and family-centred care delivered by properly trained professionals who know their patients, in well-organised teams and in properly designed premises, is the preferred model both for the rest of this decade and into the next. That is called 'general practice.' But unless those of us in the field commit ourselves to developing a discipline rather than simply processing consulters and can be seen to be ready to be proactive as against merely reactive – as has been too often the case in the past – 'general practice' might still disappear as we know it and be replaced by alternatives I will not list lest I be seen to be promoting them.

My concluding Godber quotation is that: 'The NHS depends much more on what we in the health professions make of it than on the planners.' Just what I think too! I am optimistic that the future of primary care can be entrusted to and will prosper in the setting of general practice and its teams. But we cannot be complacent.

The hospital of the future

FIONA MOSS

Change in the pattern and the delivery of health services is inevitable. Moreover, an increasing demand for good quality health care in an economic and political climate which continues to preclude any increase – in real terms – of resources for health care can be accommodated only through change.

The function of hospitals is to provide that technical expertise not appropriately sited or delivered in primary care; to look after people during some phases of some illnesses; to provide accident, emergency, and trauma services; and to provide investigative facilities and be a source of expert opinion. Hospitals are only part of a community's health services. The shaping of the future secondary care service must be primarily motivated by a quest to give consumers a better deal within the context of the whole service.

As part of a service working to accommodate the conflicting pressures of increased demands and static resources the future hospital will need three important characteristics: to have mechanisms for targeting effective and appropriate care; to be driven by service and not activity; and to have a coherent outpatient service linked to primary care.

CHANGING CARE

Some significant changes in the delivery of hospital care have already happened. For example, the average length of inpatient stay in the acute hospital services fell from 11.9 days in 1970 to 6.4 days in 1990[1]. Such changes have been reactions to external pressures and not responses to a quest for a better deal for patients. Many other aspects of the delivery of secondary care have remained largely unchanged despite changing circumstances and expectations.

The state of secondary care in London has been investigated by

teams asked to consider the provision of health care in inner London[2,3]. These reports have challenged the status-quo of the dominance of the large London teaching hospitals by suggesting that a developed primary and a community health service is the way to provide Londoners with better (and cheaper) health care. But within this recommended radical shake up there is a need to look closely at some of the many assumptions about clinical practice and define ways of making health care more responsive to the needs of the population of the 1990s. The proposed shift from secondary to primary care and the debate about future hospitals need to take into account some important and fundamental questions about clinical practice.

ROOM FOR IMPROVEMENT?

There is a growing volume of international evidence that only a small proportion of clinical interventions – 15% according to David Eddy – are based on sure scientific foundations. That is not to say that the rest are all ineffective, but simply that these have not been adequately tested. Despite a large number of randomised trials, the evidence of the effectiveness of surgical treatment for the common childhood problem of glue ear remains confused[4]. There is evidence showing that procedures or interventions known to be effective in some circumstances are used inappropriately in people unlikely to benefit. For example, a study from Trent found that 21% of coronary angiographies and 16% of coronary artery bypass surgery were inappropriate[5]. Furthermore, studies of the use of coronary artery surgery from both the UK and the USA suggest an inequitable use of this procedure[6,7]. Some interventions known to be effective are underused. For example, in a study from one hospital, β blockers and aspirin – cheap drugs which increase survival in at least the first year after myocardial infarction – were prescribed to only 40% of those eligible[8].

To some extent the use of clinical interventions is haphazard. In future hospitals, clinical management should ensure that consumers benefit more from effective interventions and be subjected less to ineffective or inappropriate ones. Coming to grips with the problems

of guidelines to help decision making may be one way to reduce inconsistencies. Changes in the content and style of undergraduate and postgraduate education and training in medical decision making and clinical epidemiology – the science of medical practice – in undergraduate clinical training will be a necessary basis for a longer term strategy.

DELIVERING SERVICES – NOT JUST ACTIVITY

The currency of hospital work is activity. In the present purchasing environment, a provider unit gets funds by selling activity. But if hospitals are to develop a constructive relationship with primary care and be shaped to respond to need rather than create demand, then the provision of services must become their core function.

For example, the provision of a service for children with glue ear might include open-access audiological services with agreed and shared indications for consideration of surgery. This service will require funding, but if this approach results in a reduction of operations a new mechanism for financing hospitals will need to be found.

DEVELOPING OUTPATIENT CARE

Outpatient services have developed in an unfocused and haphazard way. Little is known about the care provided in outpatient clinics beyond the data on waiting times for appointments and long waits within clinics. Yet, in England in 1990, over 37 million outpatient attendances were recorded in NHS outpatient clinics, of which over 8.5 million (23%) were new. This compares with 7.5 million inpatient episodes, 1.3 million day cases, and 11.2 million new accident and emergency attendances. Thus the majority of all hospital attendances (65%) are for outpatient care[1].

The future hospital will certainly contain even fewer beds and day case surgery will continue to increase. There is a real risk that the response to the crisis in health care will be to push inadequate hospital care into an ill-prepared primary care service. Outpatient care which is low tech and theoretically transferable into primary

care is a prime target for this. The problem is that we have little real idea about what happens in outpatient care.

An outpatient service includes the specialist opinion. This should be a natural and constructive link between primary and secondary care. The function of the specialist and his/her opinion is in need of review and reassessment. The clumsy mechanisms of the referral process, the use of untrained junior staff in place of specialists, and unnecessary follow-up appointments have all contributed to a devaluing of outpatient care. Training in outpatient medicine will be integral to the functioning of the future hospital, and general practitioners will be able to procure specialist help other than through a referral letter.

Changes in the type of service provided for people with diabetes illustrate a possible model for outpatient care[9]. Diabetes centres provide a wide range of advice and care given by specialist nurses, dietitians, chiropodists, and doctors. Many aspects of care are made explicit and shared among all health professional and patients. Care is less 'medico-centric.' Firm links exist between primary and secondary care and between secondary and tertiary care. With this style of health care delivery it is possible to ensure that every effort is made to minimise the devastating physical effects of diabetes and that people with diabetes have the opportunity to discuss their problems and their care.

The potential and important influence of the consumer on service provision is illustrated by the role of the British Diabetic Association in informing people about the care they should expect. This is a glimpse of the future involvement of the consumer in health care decisions.

Special features of diabetes care and knowledge about the relationship between the process and outcome of care have allowed the development of this approach to care. But this model can be applied to all outpatient care. Shared practice protocols; the scope for genuine shared care with primary care practitioners; the use of the specialist opinion as an adjunct rather than an alternative to primary care; the development of a genuine team approach to care; and the provision of real information to consumers and carers will be characterise future outpatient services.

CONCLUSION

Future hospitals will not dominate health care provision but will have a role within a network of community based care. The development of locality purchasing and an emphasis on service rather than activity will be important if the pattern of delivery of hospital care is to emerge as part of a vibrant community health service. But the effectiveness of future hospital care will depend also on the ability of the people who work in hospitals and primary care to work within a flexible patient focused health service.

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Hospitals of the future

JOHN WICKHAM

The rapidity with which patients can now recover from intervention of a lesser degree results in an extremely rapid passage through the hospital. In fact, many patients do not require the hotel services currently provided by a major hospital complex, which may well be rendered surgically redundant. Most patients can now be treated as day cases or in one-night-stay low dependency hostel units. Should we therefore not be building 'motels' with rapid transport facilities and not 'hotels' in congested urban areas?

PATIENT HANDLING

Once scheduled for treatment the passage of the patient through the therapeutic complex should be fast and well organised. Patients undergoing minor procedures are frequently put to bed and then moved to a trolley and then on to an operating table, with the whole sequence being reversed after therapy. The patient transport systems must be re-developed along production line principles with patients mounted, conveyed, and treated on a pallet, which is introduced at one end of the line and removed at the other complete with the patient and without the need for multiple transfer episodes. Hospital bureaucracy should also be streamlined to match the rapid patient transit.

THERAPY ROOM DESIGN

The present operating theatre is now inadequately provided with the instrumentation required for the performance of these newer techniques. Units will require especially equipped therapy rooms, with combined audio-visual, ultrasound, and *x*-ray facilities as permanent installations and not (as now) occasionally wheeled in and out with multiple trailing wires from dirty access corridors.

There must be specialist areas for the storage, cleaning, and rapid re-sterilisation of complex endoscopic and radiological instrumentation for immediate availability and reuse and the dedicated trained staff to manage them.

NURSING AND MONITORING

The implications for the nursing profession are that the requirement for classic inpatient nursing care will lessen, and in the future the skills required will demand a greater understanding of high technology machinery. Conventional nursing will become more community based, with patients being visited pre and post therapy in their homes. Communications and transport systems between the interventional centres and home and the community physicians and nurses will need to be very much strengthened.

Electronic ambulatory patient monitoring is technically feasible and with radio link transmission to the treatment centre a marked reduction in the need for multiple outpatient attendances would follow.

ANAESTHESIA

The specialty of anaesthesia and resuscitation will also undergo radical change in the next decade. With interventional procedures becoming less traumatic the requirement for conventional anaesthesia and analgesia will lessen, and techniques of sedo-analgesia and local block will prove adequate, and many interventions will be done without the need to completely 'turn off' the patient's whole central nervous system.

The endoscopic placement of epidural catheters, with the administration of specific drugs to a particular nerve root or areas, is already being used.

FINANCE

The financial corollary of these changes is that money should be transferred from simple hotel service to technology – which may

well become much more expensive for the reasons indicated above. Many of these changes may devolve on the district general hospital very rapidly. Endoscopic cholecystectomy within two years has become accepted as the norm for the treatment of gall bladder disease. Endoscopic endometrial ablation, endoscopic hysterectomy, appendicectomy, hernia repair, and pulmonary resection are being quickly introduced and will join with day-case arthroscopy and transurethral prostatic resection to reduce hospital inpatient stay considerably. Within a few years extracorporeal shockwave lithotripsy and percutaneous nephrolithotomy have already transformed open nephro- and uretero-lithotomy to day-case or even outpatient procedures, and one cannot stand back and say that such changes will not come in other areas in the very near future.

Even if the profession is reluctant to acknowledge this shift in treatment emphasis, patient pressure will certainly be brought to bear on those clinicians who fail to adapt their practice. The whole design of the surgical training programme needs an urgent overhaul. Present trainees are still being inducted down the path of conventional open surgical techniques, which within the next ten years may be relatively inappropriate. It is computed that 95% of cold intra-abdominal surgery will be performed endoscopically in the next two to three years. The remaining areas of open surgical intervention will be in trauma reconstruction. The majority of surgical and radiological interventions will not require open surgery, even in a fall back situation.

CONCLUSION

Programme centres and courses must be established so that interventionalists are trained in a manner similar to that of airline pilots. It is desirable that fully equipped training centres should be established with simulator laboratories where interventionalists can develop the manipulatory and visual dexterity required for the transition from open to endoscopic techniques.

The rate of change predicts the need for re-evaluation of competence – and particularly retraining of older clinicians at regular intervals with ongoing certification – but at present there are no mechanisms for this.

Thus the concept of minimally invasiveness as well as bringing immense benefit to the patient brings with it a number of consequences that need to be addressed by the medical profession, the ancillary professions, and the government. We are in the throes of a radical shift in the practice and philosophy of interventional therapy, which must be rapidly appreciated by all those concerned with modern patient care.

For the last 150 years the mortality and morbidity of surgical intervention have been accepted as part of the therapeutic process. Surely in 1993, however, this can no longer be tolerated?

Audit and accountability

ANTHONY HOPKINS

Some writers draw a distinction between responsibility and accountability. Both have linguistic origins in 'answerability', even though the Latin origin of the second word includes the verb *computare*, to count up – perhaps particularly relevant when so many computer sellers and software houses have teamed up to sell medical audit systems to add up audit data of dubious reliability and validity. The difference between responsibility and accountability does not lie in these words but in the prepositions which usually follow – responsible *for* . . . and accountable *to* . . . .

There has been a sea change in what health professionals might reasonably consider themselves to be responsible for. Until perhaps about 15 years ago, a doctor, a surgeon, or a nurse would have little doubt about where his or her responsibilities lay. Individual patients would come to health professionals with a problem, and, using their personal and technical skills, health professionals would do their best to solve the patient's problem. A tiny proportion of health professionals, of whom Sir George Godber was clearly one, saw themselves as having a much wider responsibility for the health of the nation as a whole.

Doctors and other health professionals now find themselves in a much more uncertain world. Research into the extent of variations in practice has shown that individual styles of practice vary enormously, even though individual health professionals mostly believe that each is working on a base of scientific knowledge. Marked local variations in tonsillectomy rates had been reported in the United Kingdom in the 1930s, and more recent work by Wennberg and others in the United States have shown startling variations in practice even in centres of scientific excellence. For example, Wennberg and colleagues have shown that, even when the minor variations in populations between the university cities of Boston and New Haven are allowed for, people in Boston have

Selected types of major surgery
Ratio between Boston and New Haven for Medicare patients

	Discharges per 1000	*Length of stay*
Carotid endarterectomy	2.33	1.30
Total hip replacement	1.48	1.10
Coronary bypass surgery	0.49	1.28
Hysterectomy	0.65	1.12

Data from Wennberg *et al*[1]

more than twice the chance of having a carotid endarterectomy in the former city than in the latter, yet only half the chance of having coronary bypass graft surgery[1]. Not only are there variations in rates of technical procedures: there are also variations in the way that patients are managed on an administrative level. For example, patients in Boston stayed in hospitals after their operation for 30% more bed days than in New Haven (Table). These and other types of evaluative studies have shown that the knowledge base of health professionals is much less firm than had previously been recognised. This has been one important stimulus to doctors looking more critically at the work that they do. Another stimulus has been the wider realisation that the resources for health care are limited, that individual clinical decisions drain the limited resources available, and that each health professional has a responsibility to be efficient. The reality of limited resources and the knowledge of practice variations seem to have influenced health professionals, so that they now appreciate that their responsibility extends beyond their 'contract' with an individual patient to the wider needs of society.

So much for responsibility for clinical work. What about accountability? To whom are clinicians accountable, and, as the title of this contribution implies, how can audit be useful in that accountability process?

I shall start with two people at the top – the individual patient

and the Queen. I introduce the crown first, to make the historical point that the statutes of at least one Royal College – the Royal College of Physicians of London – make it clear that its Fellows are responsible for 'the health and security of the people.' These surprisingly modern words appear in the first printed statutes of the College in 1693[2]. The medical Royal Colleges remain accountable to the Crown through the Privy Council. They concern themselves with standards of care, as maintained through examination for (in effect) entry to higher medical training, approval of posts for their suitability for training, postgraduate and continuing medical education, and, more recently, medical audit.

ACCOUNTABILITY TO PATIENTS

This brief diversion from the patient is for historical interest, but no one doubts that the first accountability of a doctor is to his or her patient, as outlined in the Hippocratic oath[3].

The Patient's Charter[4] sets out standards about waiting times in outpatients and lengths of wait on lists for procedures and so on. Important though these are, these easy measures do not really get at the heart of patients' concerns: that when they meet a doctor, that doctor will practise his or her skills at the very highest level in order to get them better, and do so in a manner that treats them with respect and kindness.

There is growing interest in how best to lock patients into the audit process, manifest by Donabedian's lecture at Oxford a few months ago[5]; the report of the Greater London Association of Community Health Councils on 'User involvement in medical audit'[6]; and Charlotte Williamson's recent book *Whose Standards?*[7]. The Clinical Outcomes Group, chaired by the Chief Medical and Nursing Officers, have also recently set up a group to consider how best to involve users in audit. Nevertheless, there are real difficulties in determining how best to do this. For example, there are reports that when a representative from a community health council was invited to sit on a district medical audit committee, the surgeons stated that they would not attend the committee. They feared that the results of any surgical audit might

be leaked to the local press, even though the person who agreed to serve already served on the local research ethics committee, and was well aware both of professional concerns and the need for confidentiality. The only way round this was to set up a parallel committee, one with consumer representation, and one without.

I have also attempted to involve the users of health services at workshops at which discussion takes place in the form of guidelines for good practice in various clinical disorders. My experience is that the closer the topic is to everyday life, then the more important is the perspective of users. For example, when setting standards for some aspects of geriatric care, we had a lot of help from elderly users, and disabled users were *the* standard setters when the Royal College of Physicians and the Living Options Group prepared their charter for disabled people using hospitals[8]. Conversely, when dealing with the highly technical aspects of how best to investigate chronic urinary infection in childhood[9], we may have caused some distress to the mother of a young child with this condition, who had not realised all the potential disasters that could befall her child. Undoubtedly, however, it would be totally wrong to write guidelines without considering the perspective of users, and this is where Charlotte Williamson's book is so good[7]. Her very title, *Whose Standards?*, underlines the need to write guidelines that should achieve outcomes that are relevant to patients rather than to health professionals. As a simple illustration of this point, doctors may strongly advise medication for mild hypertension, because the research evidence is that, if large numbers of patients are treated, a few strokes can be prevented. Nevertheless, the patient may be much more concerned about the immediate adverse effects of treatment, such as the impotence that results from some of the drugs commonly used in the treatment of hypertension. Only recently have doctors stopped being surprised at the 'non-compliance' of many of their patients with the treatment advised.

One of the difficulties about clinical audit and accountability to patients is that the values attached to health states by different patients may differ markedly. The current theme of audit seems to be the aggregation of results, and inter-unit comparison, but I am by no means persuaded that this is a sensible way for audit to go. There

is a danger that the aggregation will be of outcomes that are professionally defined. By their very different individualities, individual patient outcomes cannot be so readily aggregated.

Many doctors may have rather hoped that the standards suggested by active consumerists are not really the standards of 'real people.' There is some truth in the maxim that anyone who professes an interest towards elective office has thereby proved himself unsuitable for that office, but Charlotte Williamson marshals impressive evidence to suggest that the general standards articulated by 'consumerists' are those that many users of the health services prefer[7].

As users of health services become more active, they are likely increasingly to require audit of fund-holding general practitioners. As Jost, cited by Pollitt, writes: 'It is not clear that professional self regulation can adequately address the problems caused by medical care financing systems that create financial incentives to withhold medical care from patients'[10].

ACCOUNTABILITY TO PEERS

Until recently it was hoped that good training, good postgraduate and continuing medical education, sensitive examinations, and a professional ethos would lead to conformance with received professional standards. The importance of the practice variations described above can be interpreted as a wide variation in professional standards. Consensus conferences were popular a few years ago, and indeed the King's Fund were leaders in this particular field[11]. The focus of such work has moved in the last five years to structured reviews of the evidence of effectiveness. It is now realised that professional consensus by itself is insufficient, as there are many instances of consensus which subsequently proved to be wrong. For example, there seems to have been a surgical consensus in the 1920s that partial colectomy was a good treatment for constipation, and that many abdominal symptoms were caused by visceroptosis. We now laugh at these views, which were held by most distinguished surgeons at the time. The initiative of Professor Michael Peckham in developing a research strategy towards a knowledge-based health

service is surely the right one. Central funding has established the Cochrane centre, for structured reviews of the efficacy of various health care technologies, and the Effective Health Care Bulletins published from Leeds (e.g. ref 12).

There has also been an international effort to develop guidelines for good practice which are based on published evidence of effectiveness rather than on professional consensus[13]. Chairing as I do many of these guidelines' workshops, I am constantly amazed by the enormous holes in knowledge which I had previously thought to be firmly plugged. For example, at a recent workshop jointly with the British Cardiac Society on the management of angina[14], I learned that there is no research evidence to establish exactly who with angina should be referred from primary care. Views expressed round the table ranged from 'everybody' to 'only those whose angina persisted in spite of the general practitioner's best efforts.' Unfortunately a patient may have mild angina, and yet severe left main stem artery disease, with a high risk of early death, so that the severity of angina is not a guide as to who should be referred, and it is at present hard to see how research can improve guidance for the family doctor.

When I first began to be interested in guidelines, it was with a view to setting standards against which care could be audited. I am bound to say that colleagues have expressed much greater interest in developing the guidelines than they have in piloting the audit measures – my colleagues in geriatric medicine and in thoracic medicine being praiseworthy exceptions. Leaving that aside, however, I remain to be convinced that a critical appraisal of, say, ten sets of records of patients with stroke, reviewing their case histories, the processes of their care, and their outcomes, concentrating particularly on values of particular importance to those ten invidividual patients, is any less effective than collecting limited data sets on 200 patients with the same disorder, in order to see whether stereotyped patterns of care have been followed.

The accountability of doctors by peer review has been taken to extreme lengths in the United States, whereby by statute each State has to set up a peer review organisation. Some 3% of all Medicare discharges are subject to record review, firstly, by certified medical

chart reviewers, against the standard and rather insensitive 'quality screen,' and, secondly, if necessary, by physician reviewers (for references see ref 10). Accountability is such that, if a quality failure is identified and upheld after appeal, physicians may be 'sanctioned.' By this is meant that a sum of money may be withheld from their reimbursement, or that they may be required to undertake procedures in association with another more skilled colleague for a time. The tide is now turning against such peer review organisations because of their extraordinary expense, the relative insensitivity to poor care, and the inspectorial nature of the review process.

So far, then, with regard to accountability to peers, the professional ethos has failed to get doctors to conform to research based standards, (and I am not considering aspects of patient care such as kindness, courtesy, sensitivity, and communication[15]), and structured peer review systems have also been seen to fail. There are, however, two UK initiatives which may hold out a greater promise. The first is part educational and part peer review. Colleagues in respiratory medicine have arranged for inter-regional visits by consultants. The plan is that a thoracic physician from, say, Bournemouth may visit a thoracic physician in, say, Ipswich, and spend two days on his or her firm, generally reviewing the quality of work undertaken by the firm as a whole, making friendly and educational suggestions about how practice might be improved, and also perhaps himself learning from the visit. Experience has shown that, as the physician from Bournemouth will in his or her turn soon be visited, criticism is constructive rather than destructive. Unfortunately, this is not accountability as such, but is clearly a good example of clinical audit.

Getting closer again to accountability, we should consider the role of physicians in clinical directorates, a topic that is covered by a joint RCP and King's Fund publication[16]. Clinical directorates have grown out of the resource management initiative[17], an integral part of which was that doctors and nurses should be fully involved in the management process, in business planning, and in managing work within defined budgets. An essential feature of the National Health Service (NHS) to date has been that all consultants are equal. Not only is there parity of pay between what in other countries are

relatively low earning specialties, such as microbiology, compared to high earning specialties, such as cardio-thoracic surgery, but within a same specialty, newly appointed consultants have exactly the same rights of managing their patients how they and their patients wish as do those who have been consultants for 30 years. For example, in a directorate, tensions may arise if one consultant consumes resources by arranging scans on everybody with headaches, which, almost certainly, are due to common migraine or muscle tension. The difficulty is that his or her patients may be very satisfied by such highly technical care, but this consultant would be diverting resources which the directorate might use to achieve more gains in health. At present, the accountability of one consultant to his or her clinical director is not clearly defined. If clinical audit shows variations in practice within the directorate, it is hoped that undefined but not too directive pressures will encourage the miscreant to see the error of his or her ways. One way of solving the problem will be, of course, to allocate individual consultants a budget within a directorate, so that the overspend by an individual consultant is brought home to roost at an early stage.

Although accountability of fellow consultants within a directorate to the consultant in charge of a clinical directorate is at present weak, the tighter focus of a directorate probably makes it less easy for a clinician to continue year after year without conformance to peer standards. There have been instances in which a surgeon in charge of a clinical directorate has made it clear to another surgeon who has spent more time than might be expected away from the hospital that he or she should either reduce the number of NHS sessions for which he or she is paid, or spend the sessions at the hospital. To this extent, therefore, I believe that clinical audit has made consultants within a directorate more accountable.

ACCOUNTABILITY TO THE HEALTH SERVICE

What, however, about the accountability of doctors to health service managers on a wider front? In his talk given to a conference organised by the British Association of Medical Managers, the British Medical Association, the Institute of Health Services Management, and the

Royal College of Nursing, Robert Maxwell pointed out the need for a hinge or bridge between the management of clinical activity in health services and the management of the institution in which it takes place[18]. The 'old' model was one in which the managers provided the infrastructure of the institution, and the consultants and their teams laboured away in individual workshops, without their giving much thought to the management of the institution as a whole. In NHS trusts, the provider unit managers are clearly accountable to the trust board for the delivery of the board's policies. It is inconceivable, therefore, that management should not take an interest in the cost, volume, type, and quality of work going on in his institution. Hence it follows that managers have legitimate rights relating to clinical audit.

This principle has clearly been laid out both by the Thomson Report on *The Interface between Clinical Audit and Management in Scotland*[19], and by my own college's conference on *The Professional and Management Aspects of Clinical Audit* held there in January 1993[20]. Health service managers may well receive information from a variety of sources – users, general practitioners, staff in other departments, and so on about the quality of work of one particular department or directorate. They would be failing in their responsibility if they did not suggest that such and such was a suitable topic for clinical audit. I believe that the accountability of clinicians to managers in regard to clinical audit extends to following such suggestions, and, of course, making suggestions if they themselves are concerned about a particular aspect of their service, and making available the broad results of the audit to management.

There was general agreement at our conference that it was hopeless for health professionals to undertake audit by themselves, and then suddenly come up with a statement along the lines that 'Such and such a service is bad, and we could make it better with more resources.' What is needed is a real partnership between managers and health professionals so that managers are fully involved in many aspects of the audit process, have confidence in its reliability and validity, and can begin to see at an early stage how the results of audit might be implemented. I myself have no difficulties about this, as managers are responsible for providing the

services with which doctors can do their clinical work. It is meaningless to pretend that clinical audit can go on in a hole and corner way, satisfying managers only by the statement that 'We are fulfilling the spirit of the NHS reforms, and undertaking audit, but you cannot know the results.' This said, however, there is no denying the real need to maintain patient confidentiality at all times, and to respond in an educative rather than a punitive way to failures of quality of care revealed by clinical audit.

PROTECTING OUR PATIENTS

If clinical audit uncovers persistently poor results by one clinician or health professional, then systems need be in place to protect the patient. Some failures of care result from the actions of sick doctors, and for many years good systems for coping with such sick doctors have been in place. Although the new performance procedures put forward by the General Medical Council specifically deny any relationship between audit and these new procedures[21], it seems to me likely that one channel into the new procedures will be through the results of clinical audit. In my view it is right that this should be so. If deficiencies uncovered by clinical audit are not accountable to the General Medical Council, in at least the more worrying instances, then that may threaten continuing professional self-regulation.

AUDIT AND COMMERCE

The results of clinical audit should be considered broadly a 'free good.' By that I mean that if audit shows that a team is doing particularly well, or particularly poorly, this information should not be concealed for commercial purposes. To this extent, therefore, managers need to be 'accountable' in their turn to the professional ethic that the results of audit should not be 'massaged' in order to win contracts. It may be that of two provider units, one will feel unjustly deprived of a contract, being suspicious of the results claimed by its rival. It may be that some system of external appraisal of the audit process will be required, but purchasers have in the first

instance the responsibility for ensuring not only that effective systems of audit are in place, but also that the results are reliable and valid.

ACCOUNTABILITY OF THE AUDITORS

A final area of accountability is for those who receive funds for clinical audit. A recent health circular has set out a structure for annual audit reports to regional health authorities[22]. It is noteworthy that financial accountability is listed first, rather than that the audits have been performed with adequate methods, and that appropriate changes in the provision of services have resulted from audit. The effectiveness of clinical audit is at present under review by CASPE Research, commissioned by the Department of Health, and by the Audit Commission. My own view is that audit will not be effective until more attention is given to its methods. We need an assessment of the inter-rater reliability of audit information, better measures of outcome (particularly outcomes relevant to the users of health services), and better measures of case severity and co-morbidity. We also need more relevant methods of the measurement of patient satisfaction.

CONCLUSION

In the useful review from Martin Buxton's team at Brunel on *Medical audit: taking stock*[23], it was pointed out that there was a lack of clarity about the purposes of audit. It could be seen as meeting a range of different purposes:

- a process to monitor the provision of quality care to satisfy those external to the organisation;
- a professional educational process aimed at improving the practice of medicine by comparing individual practice with good professional standards;
- a management process to contribute to the more effective use of resources within a hospital.

Just as the purposes of audit will vary, and each of these themes outlined by Buxton and his colleagues is a perfectly respectable use of audit, then so will the pathways of accountability vary. Nevertheless, audit without accountability in the final analysis must be without meaning.

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Audit and Accountability in the NHS

NICHOLAS TIMMINS

Once upon a time there were people called district administrators. When I started out as a health reporter they plainly saw a key part of their job as being advocates for more resources for their local population. They played their part in the cacophonous public auction through which, for lack of anything better (this is just pre-RAWP*), the NHS distributed its resources by a mixture of public advocacy, shroud-waving, and special pleading.

These district administrators answered to health authorities stuffed with the voices of sectional interests – doctors, nurses, trade unionists, and local councillors. They were all unpaid volunteers. They met monthly in public, and sometimes stormy, session, with the press present. They had a distinct tendency to resist the policy (chiefly the financial policy) of the government of the day, whatever its political colour. Fourteen years of Tory rule have perhaps fatally dimmed the memory of the war David Ennals faced with health authorities as the International Monetary Fund cuts bit post-1976. But they, the administrators and the authority members, while appearing to despairing ministers at the Elephant and Castle profoundly unaccountable, were in some clear sense plainly accountable to their local communities.

Today, in the post-Griffiths-One era, we have chief executives, general managers, and unit managers. Each one has a grandparent, a performance and accountability review; a set of targets to meet; a place in a line management system that – even with the creation of NHS trusts, which makes the map rather messy – runs along a railway from the smallest siding of the NHS, through the various tiers of district and regional authorities and executive outposts, to the NHS management executive. It finally connects to the grand central station of ministers and Parliament.

*RAWP = Resource Allocation Working Party

Ministers in Parliament, however, in keeping with the Government's general drive towards agency status for everything, are increasingly referring MPs' questions to regions, districts, and trusts whenever that can be done.

ACCOUNTABILITY

This device, born of the legitimate desire of ministers not to have to answer for every bed-pan, not only disclaims the degree to which the centre is accountable to Parliament and hence the public, and that despite the fact that the new line management has given it easier access to the answers than it ever had before: it also buries the answer, for when the answer comes, it will do so in a letter to an individual MP. It will become public only if the MP understands its implications, and takes the time and trouble to make it public. It is no longer available in *Hansard* for intrusive journalists, or bloody-minded old men in dirty raincoats in public libraries in Wigan, to read and make a fuss about.

Near the top of this tree, we have the policy board. It meets in private; when and how often I doubt whether a single health reporter let alone member of the public can tell you. It discusses, we are told, strategic policy issues for the NHS. It is a closed, leak-free world, which sits atop the secret garden that is the management executive. It, too, meets in private, with no agenda published, no press present, no public knowledge of what it is discussing or of what decisions it has reached. Unlike the policy board, however, it does occasionally spring a leak to feed the well of news.

In place of the special, bleeding pleading of the old health authorities, with all their faults, we have slim-line health bodies and trusts, their chairs dominated (so far as there are any figures available) by businessmen, their non-executive members heavily weighted that way – and all of them paid. A £20m bill.

Trusts have only to have a statutory annual public meeting. The public and press are excluded from their normal business meeting. A minority so large as to be almost a majority (more than 40%) do not allow community health councils to attend. CHCs admittedly are in the main pathetic and weedy bodies condemned to suffer client

capture in return for being told anything useful, and to be condemned to the outer darkness of permanent and distrusted oppositionalism if they use what they are told to attack. But this situation – no press, no public, no CHC – rules, remember, when a key justification for trusts was that they would re-root hospitals and units in their local community, restoring both the institution's and the local public's local pride.

CHARADE MEETINGS

Many trusts, it turns out, did not even have their statutory annual meeting for 18 months after they were set up. And, when held, many are a charade. 'Extremely careful presentation,' one trust member said to me last week. 'Nothing is decided in public. We had a pre-meeting to discuss what we'd present at the public meeting. A post-meeting to discuss the public meeting. And the decisions that needed to be taken then were taken in the meetings either side of the public one.' Her fellow members – the others all have business, not Health Service, backgrounds – have no real grasp of public accountability, she says. They are there to do their best and do good, not answer to the outside world for it.

Health authorities are better; but from anecdotal evidence not a lot so. People with a knowledge as well as interest in health have not been eradicated from health authority membership; but their numbers have been reduced. And as for membership of a trade union, an Opposition party, or a seat in a council chamber which isn't coloured blue, that has become almost (though not quite) a black-ball to membership. The Department of Health claims not to know the political affiliation of appointees – and remember, now, they are *all* appointees. I don't believe it. But Baroness Denton, when the *Independent on Sunday* was exploring this issue in fields other than health recently (the health service is far from alone in becoming deeply unaccountable), said – with refreshing honesty – that, as the junior industry minister responsible for 804 public appointments a year, 'I can't remember knowingly appointing a Labour supporter.'

'Twas ever thus. Remember David Ennals facing rows for replacing Tory health authority chairmen with Labour and trade unionist ones in the days when chairs were replaced in regular thirds. But we

have now had 14 years of one party playing the game that all political parties play. Membership of health authorities is now deeply unrepresentative of the political plurality, as well as, if not unaccountable, getting somewhere uncomfortably close to it.

AGENDA SETTING

Agendas for public meetings are decided by the authority. But its members are now all paid. It no longer has the disgusted doctor, angry nurse, bitter trade unionist, or opposition local councillor seeking only to score a political point, to ensure that awkward items hit the public agenda, or are at least raised in public under 'any other business' with the press and public present. Press and public cannot raise an issue unless they know it is there. The present arrangements could have been designed to ensure that issues the authority doesn't want them to see, can't be seen; or can't be seen until the establishment decides they should be. In addition, I'm told – and this has to be anecdotes, I don't believe there is any research – that on at least one authority the conspiracy to take in part II of public meetings what should be in part I is now much more easily played. There are simply fewer awkward buggers about to stop it happening.

I am not accusing health authority members of having no sense of the public interest. Of course, they have. And I am not saying they should not be paid; probably they should be. But we are all human, and £5,000 a year, in a climate when everyone knows outright opposition is likely to lead to failure to re-appoint, cannot but require a health authority or trust member to think that little bit harder, and to require that issue to be that little bit bigger and more central, before he or she decides to take it public against the wishes of the chair, chief executive, or the authority in general. Why disturb the sleeping dog?

So what do we have in place of this lost public accountability? We have public opinion surveys and patients' charters. Fine. We should have had them years ago. But they should be an addition to more traditional forms of public accountability, not a substitute for it. For, after all, it is the authority and the trust which decide which

questions are asked, and just as importantly which questions are not. It is ministers and the executive, the trusts and authorities, not the public, which decide what makes up national and local *Patient's Charter* targets. I do not wish to belittle them – a clear definition of aims, and measurement of whether you have got there, is crucial. But the absurdity they can produce was shown in the political, not service driven, decision to end two-year waits. A two-year wait for a hip operation is a scandal. But we ended *any* two-year wait, however trivial or much more pressing another case might be; and, in places, we did so with no regard to the distortion to priorities or the impact on one-year and middle-length waiters whose conditions were more serious. That has even shown up in the national waiting list figures. Yet when we enter the recurring debate about rationing, it is only the language of priorities we talk.

PUBLIC PERCEPTIONS

Does the public give a damn about any of this? Probably not – yet. Does it matter? It does. Because the NHS remains, thank heavens, a publicly funded system, and if there is one thing Margaret Thatcher taught us it is that the taxpayers' money that goes into it is your money and my money and not the Government's money – and, while she might not agree with my formulation of it, she would agree we have a right, now severely eroded, to hold those who spend it on our behalf to account. To do that we need information and a forum, or rather series of fora, in which to do it. Both the supply of *awkward* information locally, and the forum for the cussed, time-consuming, delaying, and, yes, inefficient – but legitimising – process of public accountability have shrunk dangerously.

We have a Health Service that is far more accountable internally – and a jolly good thing too – but far less accountable externally. And in the long run, for those who believe in the NHS, the latter is dangerous. It may only be an unprovable tenet, but I believe closed systems – and the NHS is a closed system, from which most of the public have no real prospect of exit – are more open to corruption of every kind; financial, political, and the corruption of taking decision self-interestedly in the interests of the providers, than are

open systems subject to the discomfort of public scrutiny, or from which people can exit.

CONCLUSION

This is not a plea for a return to the good old, bad old days. They were far from perfect; they contained their own tensions and flaws. Health authorities that had no responsibility for raising the money were able to scream publicly at ministers who had *only* a responsibility for raising it, and damn all levers with which to ensure efficient delivery.

It will be said that we had no shortage of scandals under the old system, where life was easier for press and public, and tougher (externally, not internally, where I will concede it is now far tougher) for those in the public eye. The string of mental hospital scandals, the Stanley Royd food poisoning episode, the West Midlands decision on Quality Assurance, and the Wessex computing scandal were all taken when the old system still stood.

But those last – QA and the Wessex computers – were also the product of the new: the entrepreneurial, innovative, rule-bending, private-is-good/public-is-bad NHS, which was on the way. The new has produced much good. But it has also seen some greed, with managers convincing themselves, if only to prove in their own and other people's eyes their status, that they should be paid as much as any A-plus consultant can earn or a private sector manager achieve. QA and Wessex prove the case at least as much as break it.

I have overstated the position. But there is a real issue here. It was Dennis Healey, when Secretary of State for Defence, who cheerfully told Patrick Nairne before he became Permanent Secretary at the DHSS that 'you don't solve problems; you only change them.' The new style NHS has solved/changed for the better some of the accountability problems of the old; but it has created some serious new ones. And they need to be addressed.

Is there a place for a UK Institute of Medicine?

JO IVEY BOUFFORD

I should like to provide a brief overview of the establishment of the Institute of Medicine in the United States and some of the issues that have been raised about its successes and failures. Then I'll try to revisit (since many in this audience have been part of these discussions) some of the history of the consideration of establishing a British Academy of Medicine, look at some current UK organisations that may be serving such functions, and, finally, perhaps, try to raise some questions that can start the debate.

Robert Maxwell advised me that the issue of a British Academy of Medicine had been one raised and advocated by Sir George Godber during his career. It's not surprising that this should be so, when one reviews some of his writings and material written about him. He is clearly an individual with the big picture, a systems thinker, and one who would be an advocate for unifying voices and means for exercising effective professional responsibility in any setting. These goals are fundamental to the thinking (at least available in the literature) behind the establishment of the US Institute of Medicine and periodic debates here about similar organisations.

HISTORY OF IOM

First, a brief look at the US Institute of Medicine, established in 1972, whose birth was hardly free of controversy, and whose proper role is still a subject of considerable debate in the US.

Initially, opinion leaders in US medicine proposed a National Academy of Medicine (NAM) to develop a mechanism to 'bridge the wide gaps among government, the American Medical Association, specialty societies, academia, and industry in relation to the broad policy issues of medical practice and research'[1]. The US

National Academy of Sciences already existed, but physician members were few and very inactive. The initial debate centred on whether an academy of medicine might be an independent and co-equal organisation or should be organised separately within the National Academy of Sciences. The then NAS president supported exploration of the issue. During 1967, a number of leaders from academia, organised medicine, and physicians in government met on several occasions as a provisional board to explore the NAM idea.

There was significant debate during the following months about the purposes for such an organisation, summarised from a retrospective article written by Irving Page[1] in 1988:

- to aid government and the public to make optimal choices in public policy areas of health and medicine;
- to work with sister organisations to develop the best approaches to addressing critical problems in medicine, health, and environment;
- to undertake studies;
- to provide the public and press with thoughtful advice on current problems;
- to provide the public and the government with a medical organisation that is beholden to no one and that is representative of all aspects of medicine with unquestioned integrity and courage;
- to aid medicine in restoring itself to a position of respect and trust from patients and the public;
- to aid the public in reflecting its wishes to all branches of medicine;
- to embrace the broad aspects of medicine and help the public understand key issues facing medical practice and education.

KEY THEMES

The key themes which were sustained during the ensuing debate were the need for an independent group concerned with the many strongly conflicting trends that were becoming a reality in medicine, practice,

and research. The intent to honour members was secondary to developing a unifying movement in medicine. A particularly strong theme was that of speaking to the public with authority and integrity. There was also a strong feeling that the organisation needed to be independently resourced, if it was to provide independent advice.

Aside from the location, inside or outside the NAS, the key differences centred on whether or not it would be narrowly based in biomedical science (basic and clinical) 'speaking *for* medicine or more broadly based, speaking *about* medicine and health'[2]. In the event, the latter position prevailed and it was decided to go with an institute of medicine under the NAS rather than a freestanding entity. It would provide services in relation to medicine and biomedical sciences to the National Academy of Sciences itself and provide objective advice on critical health issues and disseminate its advice in a fashion most likely to be translated into policy.

The initial birth was turbulent. The National Academy, suspicious of its new progeny, withheld significant responsibilities for Academy activities in regard to biomedical sciences. Initial Academy funding, which had been promised, was not forthcoming, though foundation support was generous in the initial years and allowed some very important initial work to be done that put the organisation on the map, such as work on technology assessment and medical manpower. As this core funding ran out, the IOM drifted towards being a 'job shop' trying to stay afloat by taking on a wide variety of commissions. Concerns were raised about its focus and agenda, as well as its independence in picking and choosing its issues, even if the outcomes of its work were independent.

A major internal review was conducted in 1983, after 13 years of operation, which resulted in corrections of programme course, organisation, and financing, and, by most accounts, put the IOM back on track.

The IOM seeks to be an apolitical body capable of objective analysis of issues for recommending policy in health science, education, and care. It has approximately 500 members, elected for five year terms renewable for distinction and commitment from the academic and practice community in the health sciences. By charter,

25% of members are from other than the health professions – that is, engineering, ethics, law, and journalism. Members and non-members serve without remuneration on committees to study critical health issues. The issues to be addressed are identified by Congress, the Executive Branch, philanthropic foundations, private sector organisations, and the IOM itself. Examples are as varied as examination of the intramural research programme at the National Institutes of Health, a nationwide review of approaches to quality assurance in health care, and the future of public health in the US.

GOVERNANCE AND OPERATION

The IOM is governed by an elected Council of 21 members, and is organised in operating divisions of health sciences policy, health promotion, and disease prevention, health care services, behavioural medicine, and international health. There are also cross-divisional programme groups and committees addressing special issues. The Institute now oversees a programme of studies including about 60–70 active projects at any given time and the resources have shifted from an initial annual budget of $78000 to an endowment and core fund of over $20 million, largely from foundations and private industry, which permits greater independence and selectivity in the work undertaken. It is clearly seen as a resource for objective, sound policy relevant advice in the health area.

There are still concerns in some quarters whether the IOM is fulfilling its role as initially conceived. If it is, why are there so many remaining problems – technology assessment, the difficulties of dialogue between the medical profession and the public, questions of medical care financing, and health manpower. The IOM is still seen as quite distant from the practising physician and the public.

One critic argues that, in spite of the IOM's charge, there is still an explosion of new government and public organisations seeking to find answers to questions and advocate their positions. To quote this writer, 'everyone wants answers but no one seems to know what the right answers are. And if they do, their opinion is not trusted'[3]. Lundberg goes on to argue that the real clout is still maintained in the membership organisations and questions the

role of 'an elitist National Academy of Medicine in a free society where implementation of any recommendations ultimately depends on the belief and acceptance by those affected.'

Perhaps these criticisms are harsh in relation to the positive part the IOM does play, but are worth considering in any debate about establishing or 'reincarnating' an existing organisation to have such a role.

In his 1975 volume from the Rock Carling Fellowship, *Change in Medicine*, Sir George wrote a chapter on 'Progress by Consensus', in which he highlights the different strands and interests that came together, in a sense, in the formation of the NHS and especially the role of various branches of the medical profession – hospital consultants, academics, and GPs, as well as doctors in health policy positions – in these deliberations. He notes that, while sometimes government must convene specific groups to advise on its work (especially when it relates to potential demands on resources), other methods have been useful for consensus building in the UK.

He cites the pattern of securing progress through consensus on major policy issues using the device of joint working parties nominated by the Department of Health and the profession and including consultant advisers brought in as independent experts in their own fields. He identifies the Cogwheel Working Party and a subsequent working party on general practice as examples of the value of intensive work by individuals with different interests and perspectives within a policy area, resulting in recommendations that can be taken forward directly or used to form the basis for official policy or practice.

He notes 'the importance of a collective thinking process which is a necessity for an organisation like the NHS where anyone who knows all the answers has many of them wrong.' He especially emphasises the importance of informed non-medical views linked to a usual majority representation of the profession in these groups. He cautions that such devices should not be a substitute for negotiation, and raises the issues of the role of representative bodies in such institutes and academies – an issue that is inevitably part of discussions about establishing such organisations.

CONSENSUS STATEMENTS

Other mechanisms for consensus used over the years have been working groups or symposia convened by outside bodies such as the Nuffield Trust, Kings Fund, and, in clinical medicine, the Royal Colleges or special conferences called by the Medical Research Council on research issues. The results of these deliberations can then be taken up by officials or used by those on the ground to effect change 'promoting advance by agreement, rather than by Diktat.' He goes on to cite the Council for Postgraduate Education and the General Medical Council as examples of organisations emerging from initial informal conferences initiated by the Chief Medical Officer.

Sir George notes in this 1975 discussion that no single body speaks for the whole profession, even though the British Medical Association is accepted by the majority as representing them in negotiations related to their more material interests – a fact which possibly still holds true today. In this chapter, he refers to a debate a few years prevously among leaders in the medical profession who sought to promote the establishment of a British Academy of Medicine.

In reviewing correspondence on this topic published in the *British Medical Journal* in 1973, I found references to a similar debate just after the war that got bogged down in the emphasis on a physical place that would unify the various Royal Colleges. There were different points of view of the role and function of such an academy, its membership,. and the degree of support that would be necessary in terms of staff and resources. It was also noted that the call for this was coming at a time when some of the existing organisations like the BMA and the GMC were in disarray and the number of Royal Colleges was increasing, and their coordination decreasing.

Sellors and colleagues[4] advocated a body on which all the existing colleges and faculties in Great Britain and Ireland would be represented. The agenda would be: learning from each other's experiences in areas of common concern; presenting a clear and united opinion on matters of major policy; and serving as a unifying, co-ordinating voice for the different disciplines within the

medical profession. They did not see it as a place with significant staff or resources.

Alternative views were expressed by Potter[5], in a reply that advocated an academy as more of a budget holder on graduate medical education to keep it separate from the government and the GMC and to serve as a bridge between the older and younger members of the profession and between general practitioners and consultants. He, however, felt the issue of adequate resourcing and staffing was crucial, as did Stallworthy, who supported the views of Sellors on membership with links to the Royal Society of Medicine, an organisation that was founded to bring together the various disciplines within medicine in common cause[6]. The academy notion was supported by the then president of the RSM.

After a lull, at least in the literature, a *BMJ* editorial in 1979 again raised the question of the need for an academy, now citing the early successes of studies produced by the fledgling US Institute of Medicine as an example of the potential of organised professional input on policy – 'medical and allied opinion on many of the problems that need to be faced by the NHS'[7].

While the editorial writer saw the MRC as an authoritative source of advice on medical science and the colleges on training and practice quality, he or she did not feel that there was an adequate source of independent advice on broader health policy issues. A consortium of existing Royal Colleges, faculties, and specialty associations, and the BMA might form the basis for such an academy. But its independence from the veto of any of the constituent parts would need to be assured, and adequate resources would be needed to involve high quality staff and premises that could be dedicated to the work of the Academy itself. The writer cited the very multiplicity of British organisations as leading to greater fragmentation and urged the profession to attend to the need to come together to address wider needs.

OTHER NEEDS

Another individual reply to this editorial gave strong support, and added greater emphasis to the need to overcome narrow self-interest within medicine; the need for leadership; and the importance of professional and political independence[8]. He also suggested that an academy could be established by Parliament to be consulted before major changes in health policy were taken. The focus should be on professional leadership towards equity and quality in the organisation and provision of health care.

There may be more current points to make, but I think that these provide a good framework.

Of the existing professional organisations in the UK, the Royal Society of Medicine is the most 'unifying.' Its founding in the early 1800's sought to link branches of the medical profession for the 'purpose of conversation, communication and the establishment of a library.' This would not appear to be a mission statement leading to the kind of action orientation contemplated in the thinking about an academy or institute, but there might be a foundation to build on here.

The Royal Society, again, by charter, 'a UK academy of sciences, seeking to encourage and support the pure and applied sciences including engineering and medicine,' would seem more analogous (at least in aims) to the US National Academy of Sciences. In a sense the latter spawned the IOM, because of the feeling that insufficient attention was being paid to the broader needs of medicine and health within the broader scientific concerns of that organisation. I do not know if this is the case in the UK.

Finally, the public dimension noted in the US debate – communicating to the public – is not mentioned often in write-ups of existing professional organisations involved with science and medicine in the UK, or in the written debate over an academy. One exception is the British Association for the Advancement of Science, which seeks 'to promote and enhance public understanding and awareness of science and technology and their impact on society.'

CONCLUSION

So, the published debate in the UK reveals a sense of need for some mechanism that allows the medical profession to link to other allied professions to exert more unified leadership on important issues of health policy; to contribute to such a debate through studies and informed advice; and to establish a political and professional independence that can rise above sectional self-interest. The issue of responsibility and linkage to the public is less central in the thinking, but is clearly a factor. The need for independent resources in order to assure these goals are realised seems to be increasingly agreed. How or whether this would be best achieved organisationally and operationally will still require considerable debate and discussion. Perhaps we can start the process here.

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Medicine in society, now and in the future

GEORGE GODBER

Last autumn, during a conversation with Robert Maxwell on some of the matters with which this symposium is concerned, he asked if I would come to it on this date. Of course, I wanted to listen, because I'm well past the date when I should talk to you. Just five weeks ago I discovered that you were all coming and that the symposium carries my name. I can say only that the generosity of the King's Fund to my family and me is equalled only by the pleasure it gives me to meet and hear so many friends. I guess the oldest in friendship, if not in years, is Francis Avery Jones: we worked together 47 years ago under the chairmanship of Ernest Rock Carling formulating the Hospital In-Patient Enquiry, along with Percy Stocks, John Ryle, and Alan Moncrieff. I have gone on learning from so many of you – including those born since the mid-1940s, perhaps especially those – ever since.

I will not name any more names, but just say that your participation here today is the greatest compliment I have ever received. I thank you all, the King's Fund for their generosity, and Robert for bringing it all about; and I know Norma and our family would say the same.

CONCEPT OF NHS

The concept of a National Health Service was not new in 1948. William Beveridge in his report just assumed that it would be set up as one of the props of the kind of responsible society he envisaged. A lot of doctors of my generation always believed that it must come, without having very clear ideas how. I've always thought the best reflection of public attitudes was given by Richard Tittmuss, in one of his essays, quoting the comment of an elderly Civil Defence worker just after the war, that stress 'had made us realise that we were all neighbours.' Some politicians notwithstanding, there *IS* such a thing as Society.

The 1944 White Paper produced some principles, and Henry Willink as minister began negotiations – and got bogged down. Bevan came in with the new government in 1945 and cleared the air by two radical decisions: that the NHS must be universal and that the hospitals needed such fundamental reorganisation that they must be nationalised. I remember how that revived the spirits of one of the hospital surveyors of 1942–4. Without those two decisions we might never have produced the effective NHS which was to give us the least costly and most comprehensive system of health care in the developed world *at that time*. It could be surpassed, in particular, but it had fewer lacunae and greater popular support than any other known to me.

The changes were necessary to medicine and nursing for their own development – specialised medicine at region and district levels; general practice at community level; and nursing at community and district levels. Specialised medicine was in the early stages of development with grossly inadequate deployment. Without the NHS, adequate training could not have reached the periphery so quickly. Nurse training needed regrouping, and community nursing wider development. General practice needed grouping in alliance with community nursing. But the most important change was the involvement of people as a whole in the process. The NHS had to be, and be seen to be, a public even more than a professional concern. It took at least the first dozen years for that to emerge and the full development has not yet occurred. Indeed, one of the greatest dangers I see now is of standardised services deployed for our use by a competent management in which we, the users, have too little voice.

RADICAL CHANGES

The health professions in the last 45 years have had to achieve radical change in their own internal relationships, in their relationships with each other, in acceptance of new scientific colleagues of equal standing, and in their exchanges with patients as equals, entitled to explanations and full participation in decisions. Medicine is no longer a mystery or a dogma: much of it is measurable and

definable in terms the users can understand, and the press constantly debates, sometimes in partisan or confusing terms. There is always some self-appointed expert ready to opine.

In those 45 years medical science has advanced far more rapidly than in any comparable period in the past. There are three times as many specialties recognised now as in the original development plan, and each has to be available, though not necessarily located, in every district. Development has been partly programmed and partly a lagging attempt to keep up, often with conflicting advice. The administrative structure was bound to need change, but too often this has led to greater centralised control. It's far easier to live with your own mistakes than those of central authority – and easier to change. Conservatism in medicine has frequently impeded needed change, especially in the structure of hospital staffing, and management did not envisage it or readily finance it. Successive generations of registrars and senior registrars have been unjustly held back more by their seniors' resistance to change than by cost. Through that delay too much initiative has been lost. The changes that will have to be made now could and should have been initiated 25 years ago, and for that failure I share the blame.

General practice, by comparison, began the process of regrouping in the 1950s, after carrying the heaviest burden of the early years. The foundation of the Royal College of General Practitioners, the developing association with community nursing, and the initiative in postgraduate medical education of the 1961 Christ Church Conference led up to the Charter of 1966. Jim Cameron and Kenneth Robinson will always be remembered for that. Modern primary care is not merely a system of medicine: it is multidisciplinary, and, at its best, has taken on patient participation far more than has hospital medicine.

PAST – AND FUTURE

I hope you will forgive this commentary on the past, but it does have a bearing on the future. Some of the language of the market seems to imply that the need for health care can be met by shopping from a list of standardised and mass-produced services. There must indeed

be more uniformity within guidelines on the best care in many circumstances – and those guidelines will increasingly be available to users as well as providers. But the needs of individuals cannot be standardised in the same way as mass-produced products in other markets. The health professions have to adjust and adapt the services to users' needs, with their consent. At any one time the users are made up of at least eight 10–year age groups and the providers of three or four such decennial cohorts – to use the jargon.

Recently asked to talk to the final year students at Cambridge, I had to wake up to the fact that they were 60 years ahead of me, with a far more advanced frame of reference in their medical science and possibly a truer appreciation of some of the social factors in modern health care. The response to that surely must be that all members of our health professions – especially medicine – should accept fully the obligation to pool knowledge and communicate about the progress that occurs at ever increasing speed. Market or not, the ethos must be to collaborate rather than to compete. When John Charnley, 40 years ago, developed his system for hip joint replacement his first concern was to pass it on to others to use. So must we do the like now. In no area is that as important as on both sides of the interface between hospital specialised and community generalised care. One cannot be fully effective without the other.

PARTICIPATION IN CHOICES

There is another area in which users must be given more chance to participate in choices which must be made. It has never been possible to do all that medical science makes feasible in diagnosis, treatment, prevention, or even palliation. Some things will have to be left undone, and they should be chosen deliberately and overtly. Some of the choices are humane and justifiable to avoid painfully prolonging the process of dying. That issue was clarified 25 years ago by an advisory group on the use of surgery in newborns with gross spina bifida. It arises again now over the decision not to resuscitate after cardiac arrest. But there are also conditions in which very high cost procedures offer some hope of at least partial success, but would require the use of large resources – not just

money – which could be better used for the far more certain benefit of many more patients.

All this is not a new dilemma. When stretptomycin first became available in limited quantities just after the war, the supplies were deliberately used only for the treatment of early pulmonary tuberculosis and tuberculous meningitis. We were still subject to food rationing and there was not the slightest demur about the policy. Some 20 years later the provision of haemodialysis and then renal transplantation were similarly subject to priorities. In my view we will need to discuss openly broad guidelines about limiting investigation and treatment, not exactly in the pattern John Kitzhaber introduced in Oregon but in an agreed and constantly reviewed way suitable to the NHS.

CONCLUSION

All the decisions we need are not managerial fiats but guidelines for local interpretation by providers and users together. We must never forget that the new market in health care is a device to secure maximum effective use of limited resources; it must never become a mechanism for profit.

Medicine in society, now and in the future

PROFESSOR IAN KENNEDY

I doubt my right to be here, Sir George. Some 13 years ago I had a few moments of glory. Since then I have withdrawn back to contemplation and penury, which is, of course, the proper condition of an academic in a country which so highly values education. Further, I have no doubt that the previous speakers have already made most of the points I would want to make. I could, of course, review what I said some long years ago, ask what has happened, and then, perhaps, leave you to wonder what the future will bring. I am not going to do that, except to notice two things. First of all the good news, followed as you may guess by the bad news. The good news from my professional point of view is that, since I gave the Reith Lectures some 13 years ago, there has been an undoubted shift in the attitudes of the medical profession: in their concern for patients and for patients' rights, and in the visibility of the notion of medical ethics. There is even a slow recognition of the need for clinical guidelines and standards, which I do not want to talk about today, as a further step towards accountability. Finally, there seems a greater preparedness to admit the limits of medicine in health care. All of these are, I think, significant advances.

The bad news, leading on from what I said those many years ago, is that, in my view, firstly, *medical care* still dominates discussions about health, albeit that there is something of a shift in funding towards prevention and primary care. Secondly, organisational considerations again dominate discussions about health. There seems increasingly less account taken of patients' needs and patients' rights as management and infrastructure are the focus of debate. Patients' charters have to be seen against the background of a review of the welfare state. A review is called for because too much is being spent in benefits, it is said; a wonderful example of blaming the victim if I ever saw one. Equally, charters of rights have to be seen against the increasing shifting of the tax burden, so as to

promote a climate for a widening division between those who have and those who have not. This inevitably is reflected in the purchasing power of citizens as regards all commodities, including medical care and that which promotes health.

Thus, while some can afford to join a health club, others must play in the street. Our society, Sir George, if I can use that word, is one which more than ever knows the price of most things and the value of very few. Particularly as regards what I have called the bad news, when we look at health, the context is one of increasing poverty, both real and relative, homelessness, declining provision of education and nursery care, unemployment, crime, and helplessness. Some may dismiss this as the unreconstructed ramblings of someone fixated in the '60s. Of course, we know that the '60s are now subject to what is called the rewriting of history. We are led to believe that the '60s was a period of absolute horror for all of us who have lived through it. There were, of course, fewer Mercedes. There were also fewer beggars. I could, of course, be confronted no doubt with data which would seek to demonstrate how wrong I am. I do not think I am. General formulae will not hide my concern for what it is, a concern for justice, which cannot be hidden in management-speak. Thus, Sir George, I am still as angry as I was when I gave those lectures a long time ago, even though I now wear a suit.

MEDICINE IN SOCIETY – THE FUTURE

But this is not what I want to talk about. What I want to talk about is rather something different, something really rather unusual for me. I have to remind myself sometimes, and my colleagues are very rarely persuaded, that I am actually a lawyer. So I want to talk as a lawyer. I want to talk about medicine in society – the future viewed from an unusual perspective, that of a social commentator interested in law. And as a lawyer I want to warn you that I too see the changes which you have all been talking about today as regards health care, in terms of ideology, in terms of rhetoric, in terms of organisation.

With these changes come changes in attitude and in expectation.

Whether it be in patients (or there is a new word apparently, users), or whether it is in those who control the system, managers. The sense of belonging to a flawed but noble enterprise where everyone gained a little bit by giving a little bit, where the system tried to do its best by all for all, is going. Indeed, it has gone as regards to 20–30 year olds, the children of the '80s. Rather, the language is now of consumers, providers, purchasers, charters, enterprise, targets. There is no such thing as community, no such thing as society. Well, these changes in ethos, in the sense of what medical care is (a commodity rather than a shared entitlement), in the notion of the NHS, will, I predict, unless something dramatic is done, produce a sea change in the role of recourse to law. It is not something I say with glee first because I am a lawyer. But, you will understand that the law is quite familiar with, it deals every day with the language of consumers, users, charters, purchasers, and contracts. This is the language of law, especially when coupled with accompanying rhetoric about rights.

The law will, in my view, be inductably drawn more and more into the provision of medical care. Frustrated by a dislocation between expectation and reality and, taking the rhetoric at its face value, patients will ask for their rights. Faced with no accountability in Parliament because everything after all is devolved to some other agent which does not have to answer in Parliament, patients will go to court. Equally, managers will dig in when faced with budgetary restraint, and if necessary, go to court. And, not to be left out, health care professionals will chafe at the restrictions they confront.

CHANGE: INEVITABLE AND PROPER

Of course, change is inevitable and proper. Change in the direction of health care service is inevitable and proper. But the changes of the kind which we are currently witnessing will produce the results which I am predicting here. Already you can see a growth in plaintiff's lawyers, lawyers representing patients as plaintiffs. Fifteen years ago, they were as rare as hens' teeth. There were only defence lawyers and there were only two major firms of those. Now there are significant numbers both of lawyers and of organisations

concerned with access to and use of the legal system on behalf of patients. The courts will be drawn in whether they like it or not. Social moral and medical policy will be made more and more by courts. The great irony is that they will do so as defenders of patients' rights. In other words, the rhetoric rights which is going to create the problem is then going to be used to try to solve the problem (the rights of patients).

Hitherto, courts have been tender to health professionals, although some of you are occasionally persuaded otherwise. They have kept their hands off the health care system and health care professionals. Indeed, until very recently there were very few decided cases in England. Medical law was largely undeveloped, in contrast to the situation in the United States. There, the courts have long been occupied with mapping the development of medicine through cases brought before them. The reason for this is undoubtedly the commercial nature of health care and the consequent insistence by patients of their rights as consumers.

CHANGE IN SIGHT

The cosy English tradition is, however, set to change. Let me give you some examples. Firstly, the courts will be asked to adjudicate on issues concerning access to health care. Courts will be asked by patients whether it is justified to discriminate against them on the basis, for example, of their age, or to make them wait longer than others, or to deny them certain care. Mental health patients will ask 'What is all this talk about community care?' Victims of those who are mentally ill will begin to complain, asking, 'Why are some ill people left neglected such that their illness causes them to attack others.' GP fund-holders will be asked by patients, 'Why is so-and-so jumping the queue?' There may well be answers to these questions, but they may none the less end up in court. Patients will ask of hospitals and managers, 'Why have you closed down that ward, that department, that unit, that service? What about the Patients' Charter?' or 'Am I not entitled to this; I have been paying my dues?' Patients will also ask 'Where is all that preventative care that I am supposed to be getting? Is that not part of my entitlement?'

Access to health care, therefore, will be a fertile field for people to go to court, not least because they will come to feel that they will not get satisfaction anywhere else. They have been persuaded by the rhetoric which is now the rhetoric of political exchange.

Secondly, access to information and control over information will be more and more a subject of litigation. Patients will want their personal data regardless of arguments that it will not be in their interests to obtain the information. They will want to see what is in their notes. To cite just one modern development, they will want to find out about genetic data. Further, they will want to know about their doctors. They will want to know whether information exists about the relative skills and competence of doctors and if it does they will, quite naturally, want to see it. They will not settle for confidential or anonymous studies just because doctors say it is in the public interest that such information is not made public. It was argued by Nick Timmins that such a secret system was defensible as a doctor can be forgiven if he has made a mistake. Such an approach may get short shrift in a new environment of litigation. After all, why should a patient who is injured be forgiving? There will be calls, even demands, for access to information about audit, about success rates, about whether a doctor is currently being sued, about which grades of doctors are seen as an outpatient. Patients will wish to know how a doctor measures up to the national standards and guidelines, whether these are observed, even whether the doctor knows what they are, and whether protocols have been drawn up.

Next, within this notion of information and control over information, there is concern over confidentiality, not necessarily in the average GP/patient exchange, but, for example, in the context of employment, especially as regards genetic information sought by employers who would want either to discriminate or otherwise select whom they employ and who they do not. I could go on. A case in the Supreme Court of Canada has recently redefined the doctor/patient relationship as a fiduciary one. In other words, it is a relationship in which there is an obligation on the part of the doctor to act honestly, to disclose everything, and to act *exclusively* in the interests of the patient. The English High Court in the case that arose in May of this year, R *v* Mid Glamorgan FHSA *ex parte*

Martin, brushed the Canadian case aside as being, in essence, a foreign decision. But the question of the true legal nature of the doctor/patient relationship will come back.

OTHER ISSUES

So, I have mentioned access to health care, and control of and access to information. I could talk about other things – for example, particular treatment decisions which will come before the courts. Not just the difficult ones, such as the case of Tony Bland, or the patient in a persistent vegetative state, or that or sterilising incompetent women, or what we do about Jehovah's Witnesses. There are lots of other issues which press for solution. How, for example, should we care for people in nursing homes, or what is to be done with young girls who are anorexic or in other ways refuse to comply with what they are advised? In my view, in such cases, involving particular treatment decisions, the role of protocols and guidelines will become more and more significant in determining whether a doctor has violated the law.

I will mention two other sets of circumstances into which I foresee the courts being drawn before I conclude. Firstly, managerial decisions will be increasingly challenged before the courts. The difficulty of holding managers accountable through any political process, which Nick Timmins spoke of, will lead to their being challenged in the courts. Even the constitutionality or legitimacy of the very basis on which decision may be reached may be questioned, by both patients and staff, and, lastly, but by no means least, by the health care professional. Finally, the working practices and employment within the NHS and particularly in NHS trusts may well come before the courts. It is all very well to urge doctors and nurses to speak out against what they see as undermining patients' interests, but if the contract in the NHS trust forbids this, then the professional will think twice. In such a case, the legitimacy of managerial decisions will be something which will be challenged in the courts.

CONCLUSION

The courts, of course, being, as I said, tender towards health-care professionals and not wanting to get into these areas at all, will not be delighted to accept this particular poisoned chalice. But they will not be able to avoid it. The one thing courts cannot do is to refuse to answer questions brought before them. And they will have a rough ride if they frustrate patients, who after all have been led to believe that they have rights. Equally, they will have a rough ride from government if they satisfy patients even though it is government policies which have brought them there in the first place. So, as a lawyer I look forward but, I repeat, with no sense of glee, to the courts, and that means the judges, making medical care policy and health-care policy.

Medicine in the future, as seen from my little corner of the world, will be full of law and rules and watching your back. If you do not want this to be the case, then the language and ethos which now predominate will have to change and change quickly. This is because the old alliance of the welfare state has gone, sadly in my view, just when many health-care professionals were beginning to fight for it. So, beware, and do not blame the lawyers. They are just as interested in patients' rights as doctors; they may just sometimes see those rights differently. And, they will be responding to patients' perceived needs when no one else is.

Medicine in society, now and the future

KENNETH CALMAN

This is a topic of considerable importance. Unless we stand back now and look at where we have come from and where we might go to then we will not be able to provide the vision for improving health. Medicine, and its purpose, is clearly related to the society in which it functions. The relationship between the two is, however, worth examining in detail.

THE STRATEGIC FRAMEWORK

To deal with medicine in society requires a visionary strategic framework. The following is suggested as it links clinical and public health practice with society as a whole:

- to promote efforts to ensure health for all. All sections of the community should be able to achieve the best of health and health care; identification of those factors which influence health and health care is essential to us
- to achieve *Health of the Nation* targets in the five key areas
- to involve patients and the public in choices and decision-making
- to develop an intelligence and information system from public health and clinical practice and to create mechanisms to translate this into action to improve health and health care
- to ensure a health service based on an assessment of named quality of care effectiveness of outcome and with full consideration of economic and resource issues
- to provide a highly professional team of staff (health-care professionals and managers) founded on a strong educational and research base and associated with clear values and high ethical standards.

Each of these main aims will now be discussed in turn and this will then be followed by a brief review of the purpose of medicine in relation to society as a whole.

Health for all must take into account the most disadvantaged sections of the community and the provision of the best in health and health care for all. This will not be an easy task but equity remains central to our society, and to medical practice.

The *Health of a Nation* targets are realistic targets and their attainment would see considerable improvements in health in this country. They are based on both healthy alliances and healthy settings. They must be seen not as government initiatives, or those related to the National Health Service. They must be seen as a national response in which all sections of the community are involved. It raises the general issue of the purpose of health and whether it is a means or an end. For this presentation health is seen as a means to improving quality of life, not as an end in itself.

INVOLVEMENT

Patient and public involvement is essential if the views and wishes of society are to be part of making choices and decisions. The Oregon experience has shown some of the benefits and disadvantages of this. However, to look ahead, this is clearly an area that must be developed further.

The intelligence function requires that we identify new diseases and old ones which are changing in incidence or severity. It also requires us to look carefully at variations in health and the outcomes of health care and to pick up changes in public perception of health and illness.

Education is seen to be one of the keys to improving and changing health. However, it must be much more responsive to the needs of society and recognise that the medical curriculum is once again not an end in itself, but must be related to health needs and the expectations of society. The research basis is crucial to this as is the need to ensure high ethical standards.

THE PURPOSE OF MEDICINE

From this brief review the following definition is then offered of the purpose of medicine: 'to serve the community by continually improving health, health care, and the quality of life of individuals and populations by health promotion, prevention of illness, treatment and care, and the effectiveness of resources.' This must be done within the context of the health-care team and the community and in relation to society as a whole. Thus the role of the doctor might be defined as:

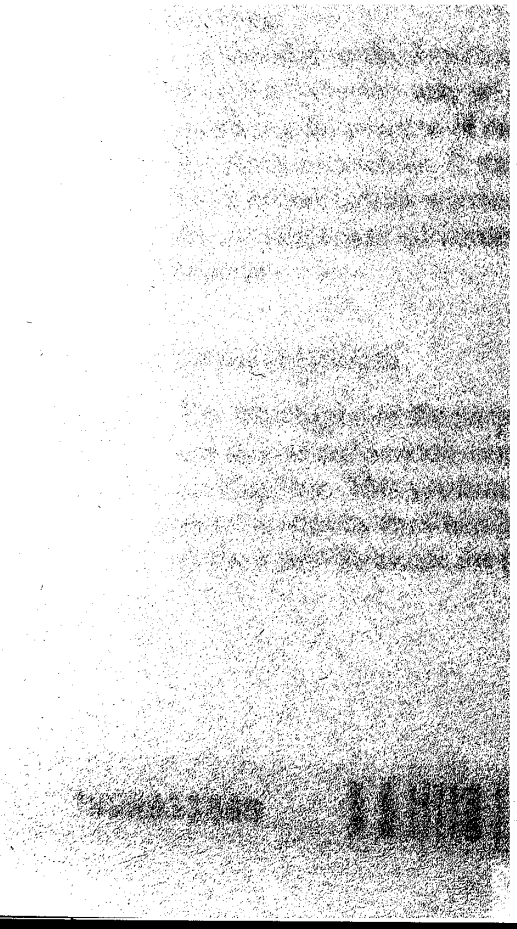
- providing the highest quality service to an individual patient;
- having responsibility for the community as a whole; and
- consideration of the careful use of resources, including skills, time, and finance.

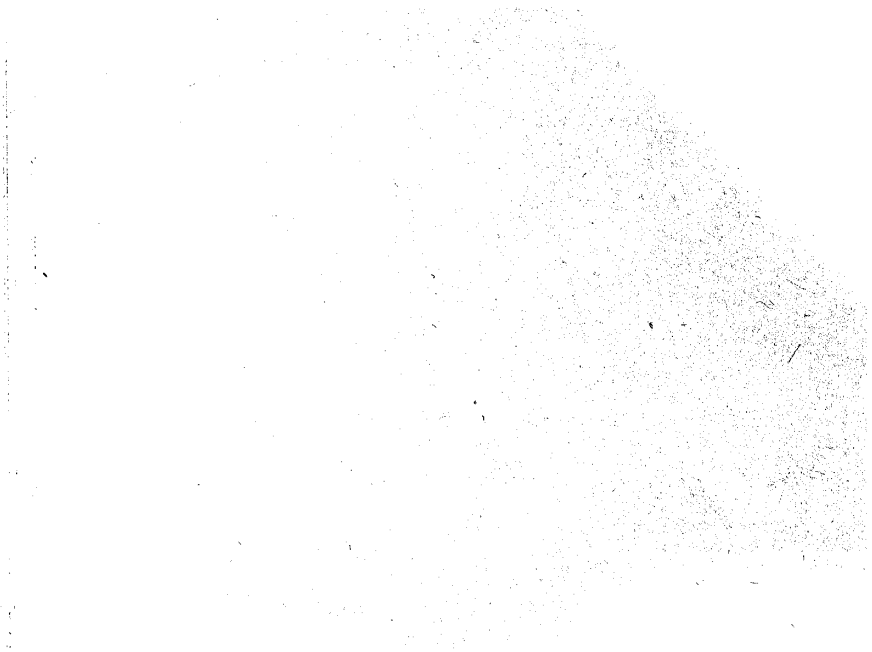
This role must be based on the number of important values, which might include putting the patient or the public first, ethical principles, high clinical standards, and the willingness to continue to improve.

Education is the key to change, but it does question the kind of doctor required to take us into the 21st century. It is partly about redefining the purpose of medical practice and recognising the needs in society as a whole. It must also consider the curriculum and the kinds of individuals selected to become doctors. It should be based on an assessment of competence and a regular review of clinical practice.

CONCLUSION

The redefinition of the purpose of medicine is crucial if we are to see our way ahead into the next century. The challenge, however, is an exciting one. This presentation has highlighted some of the main issues as seen by the Chief Medical Office and I hope that discussion of them will illuminate the future.





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