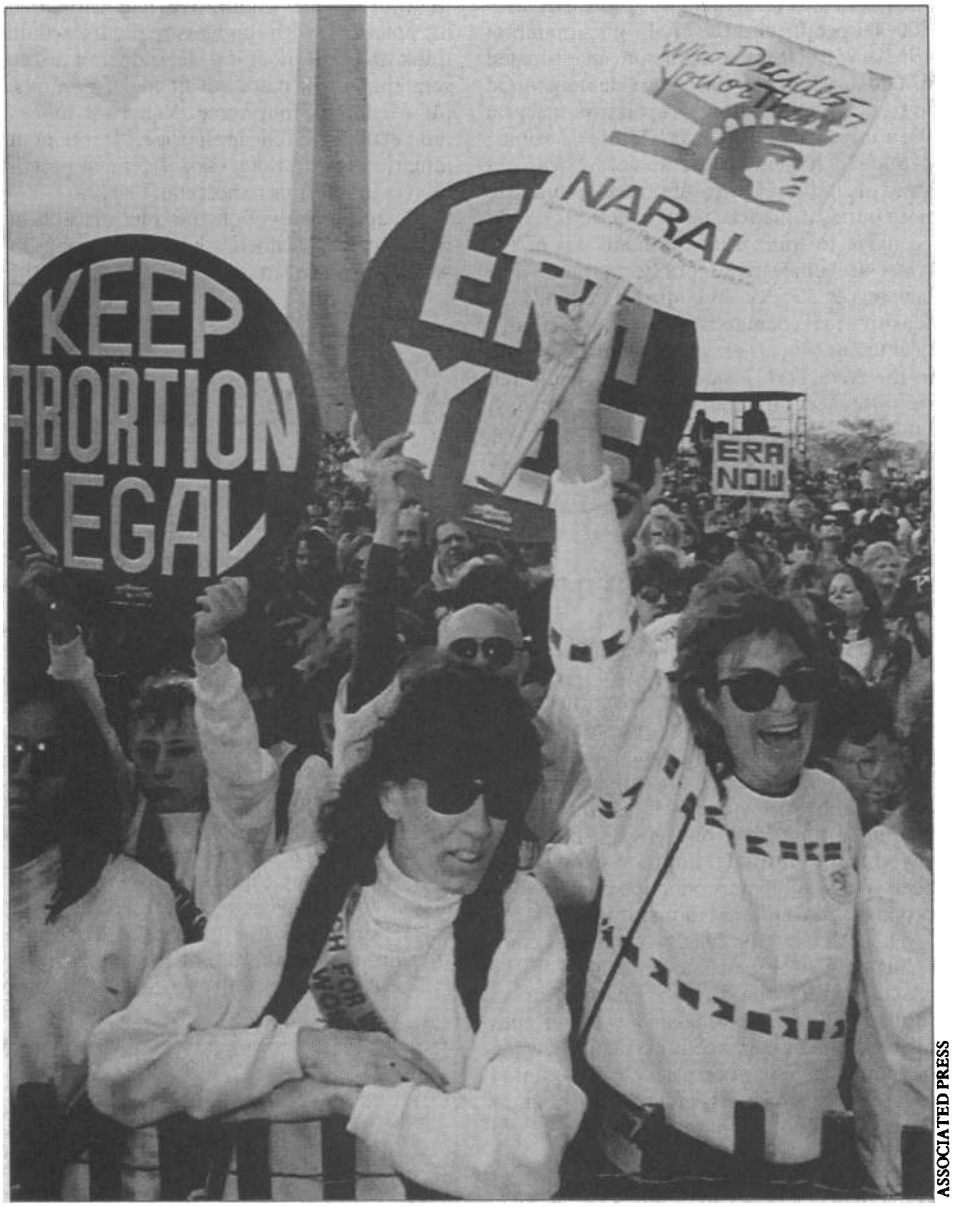
American abortion debate

In Britain the 21st anniversary of the implementation of the 1967 Abortion Act is on 27 April, and campaigners from both sides of the debate will be using the opportunity to put their cases. The debate on abortion is also raging strongly in the United States, where on 25 April the Supreme Court will hear arguments in a case concerning the constitutional position of a law passed in the state of Missouri in 1986 restricting abortion.

Although the court is unlikely to reach a decision until the summer, the hearing is attracting nationwide interest and observers are trying to divine the outcome from the way the judges are questioning both sides in the case.

The Missouri law limits the availability of public funds and facilities for abortion and even seems to restrict what doctors may tell patients about abortion. It also puts up obstacles to abortion after the 20th week of gestation and requires doctors to perform tests to determine fetal viability. The legislation contains a preamble stating that life in humans begins at conception, a view that is by no means accepted among medical scientists. The law, however, has never been implemented; since its passage it has been successfully challenged by the Planned Parenthood organisation. Two lower courts held its provisions to be unconstitutional, and Missouri appealed to the Supreme Court, which in January agreed to consider the case.

The case has stimulated a record number of friends of the court briefs on both sides of the issue—78, according to the court's spokesman, made up of 45 antiabortionists, who argue that the Supreme Court should overturn the lower courts' decision, and 33 opponents, who plead the case for the right of women to obtain an abortion.



ASSOCIATED PRESS

Proabortion protestors at the rally in Washington on 9 April

Interest in the case has been heightened by the decision of the Justice Department to join Missouri's argument that here was an opportunity for the court to overturn its landmark decision on abortion—the famous Roe versus Wade case— in which the court held that a right to abortion is part of the constitutionally protected right to privacy. President George Bush and his predecessor Ronald Reagan have indicated that the Roe *v* Wade decision should be reversed. In the interim the membership of the Supreme Court has changed appreciably— at least four of the justices are thought to be in favour of reversing the decision. The last major abortion ruling by the court in 1986 was decided by a five to four majority; since then Justice Lewis Powell Jr, a supporter of abortion rights, has been replaced by Anthony M Kennedy, who has not expressed his views on either the Roe *v* Wade case or abortion generally.

Thus, at least in the minds of some, there is a serious possibility that the Roe *v* Wade case will be overturned by the court. Most legal authorities think this will not happen, arguing that the court is more likely to deal with the Missouri law and its alleged unconstitutionality on much narrower grounds. And even if the court does reverse the lower courts' decision the number of abortions is unlikely to be affected as most are performed in private clinics. But the perception that it was even conceivable that the court might reverse the previous ruling and make abortion illegal once more in the United States brought forth an astounding public protest in Washington on 9 April—those in favour of leaving the issue to individual women in consultation with their doctors finally decided they had to speak up.

For years abortion clinics have been picketed by antiabortionists and some have been bombed, and in many states legislation sponsored by the antiabortion movement, such as restricting public funds, has chipped away at women's freedom to obtain an abortion, although abortion is still legal. The antiabortionists are a vociferous group and as such often seem to be more powerful than they really are. For the past dozen years or more protests against legalised abortion have received wide attention and considerable respect from elected officials.

The Washington march put the antiabortion protests into a social and political framework that will probably have a permanent effect. By bringing out one of the largest

crowds seen in the city in many years it unequivocally showed public opinion; the movement in favour of choice was reborn.

Conservatively estimated at 300 000 people, the numbers were greater than expected and were comparable with those attending previous events that have been turning points in modern American history, such as the 1971 Vietnam war protest of up to 500 000 people and the civil rights march of 1963 of 250 000. By comparison, an estimated 67 000 antiabortion protesters demonstrated in front of the Supreme Court last January on the anniversary of the Roe *v* Wade decision.

Such demonstrations, however, will not sway the judges. Courts of public opinion are not courts of justice; nevertheless, it would be naive to think that the members of the court are unaware of public opinion. The law serves society and must eventually be sensitive to its demands. As Paul A Freund, a prominent scholar of constitutional law, said in the *New York Times*: "Judges should not be influenced by the weather of the day, but they are necessarily influenced by the climate of the age."—CHARLES MARWICK, *Washington*

No tablets of stone

A headline in the *Independent* of 12 April read: "Ministers may back down over fixed drug budgets." The past week has seen several indications that the proposals in the white paper *Working for Patients* and in the new contract for general practitioners are not set in tablets of stone. Mr David Mellor maintains that this has always been the government's attitude, but most people have been aware of it only as opposition to the proposals has gathered momentum.

The Minister for Health made his comments in a health debate organised by the Association of the British Pharmaceutical Industry. Listening to what was being said, his department paid heed, particularly when the points were put persuasively. He wanted to see a sensible settlement on the new contract and not an imposed one, but he did not think that that would be necessary.

What the government wanted to do, said Mr Mellor, was to build on the achievements of the past 10 years—when the number of GPs had increased by a fifth and of support staff by a half. The new proposals would stimulate and reward effort. Why should general practitioners who did not provide a comprehensive service be paid the same as those who did? Why should doctors be paid more for how long they had been in practice and for the number of patients on their lists? The government could not sit back and accept the current variations in standards.

As to the white paper, the minister was concerned that so much attention had been focused on the proposal for some practices to hold their own budgets. It was not one of the main proposals. And he doubted whether patients would rise up against indicative drug budgets. No professional person could ignore the need to be cost effective in prescribing.

Mr Mellor disagreed with Sir Christopher Booth, president of the Royal Society of Medicine, that the proposals would increase inequalities in health. If doctors were rewarded for improving primary care and people could cross boundaries inequalities would be reduced. Medical audit would allow outcomes to be judged properly. Dr M A Wilson (chairman of the General Medical Services Committee) had feared that in practices with budgets patients would think that the doctor's decision not to do something was made on financial grounds. Mr Mellor did not agree. Value for money did not mean the cheapest price. "It is not our intention to clip the wings of general practitioners in referrals to hospital," he said.

A representative of the pharmaceutical industry complained that the proposals would stop investment in research. But the minister pointed out that the NHS was a £2bn customer of the drug industry—it was willing to pay large sums but not for branded medicines. And, Mr Mellor maintained, the industry had used just the same argument over the limited list.

The debate was ended with the surmise that the audience was sitting in one of the richest health authorities yet close by people were living rough, elderly people had no general practitioner, and, possibly, children were being abused. Stating this, the general secretary designate of the Royal College of Nursing, Miss Christine Hancock, emphasised that those were the people that improved primary care should be helping. There was far too much talk about reorganisation and not enough about health care and health promotion.—LINDA BEECHAM

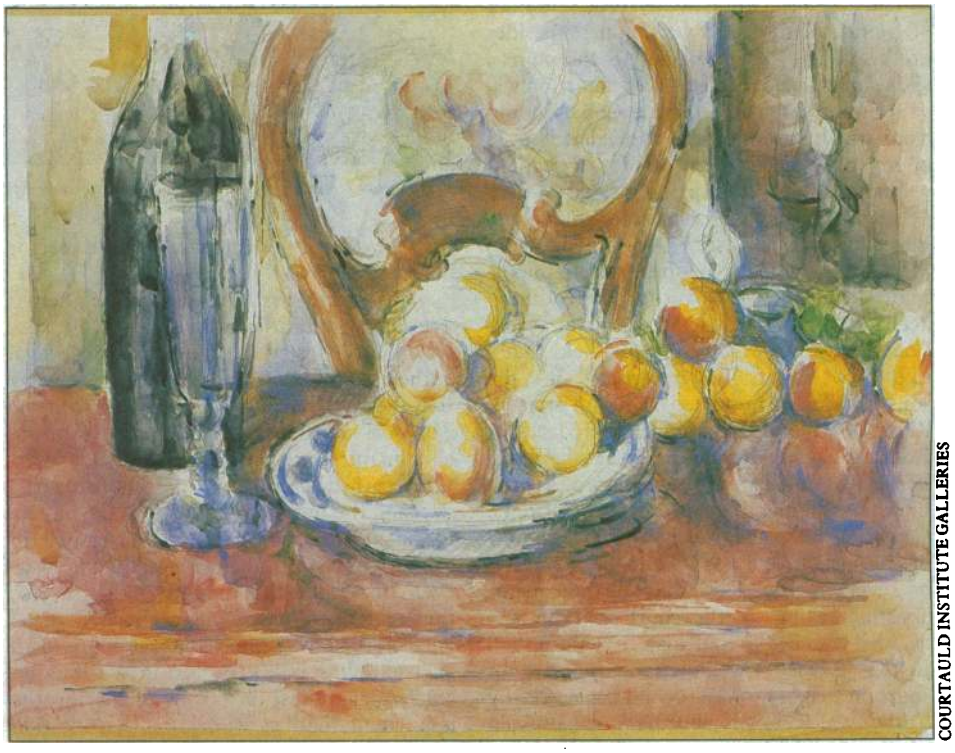
An apple a day . . .

Last week Britain's apple eaters were told by radio, television, and the newspapers that rather than keeping doctors away these fruits are now suspected of causing cancer.

The apples themselves are as wholesome as ever—the hazard to health comes from the chemicals sprayed on to them by farmers. The prime target is Alar (daminozide), a pesticide used to protect apples from attack by insects. The chemical penetrates the skin of the apple and cannot be washed off so that it finds its way into apple juice and apple sauce. The environmental pressure group Friends of the Earth is calling for daminozide to be withdrawn immediately, but last week the Ministry of Agriculture referred the matter to its advisory committee on pesticides, which was due to meet on 20 April, after this issue of the *BMJ* had gone to press.

The alarm began with a report in February this year from the United States National Resources Defense Council. This environmental group alleged that around 6000 children may develop cancer later in life from their exposure in infancy to eight pesticides including daminozide. It claimed that the United States Environmental Protection Agency was disregarding children's health. A report in *Science* (10 March, p 1280-1) said that the National Resources Defense Council was threatening to sue the Environmental Protection Agency for its "systematic failure to protect children." In reply the agency asserted that the risks were small and outweighed by the benefits pesticides brought to society.

As *Science* observed, behind the panic and the disputes are some reassuring figures. There are 22 million children in the United States under the age of 5, and on current estimates 5·5 million of these will eventually get cancer. So the extra 6000 represents an increase in risk from 25% to 25·025%.



COURTAULD INSTITUTE GALLERIES

Nevertheless, 6000 cancers seem to many Americans to be 6000 too many, and the Environmental Protection Agency has decided that use of daminozide should be phased out; it proposes to ban use of the pesticide sometime in 1990.

Here in Britain apple growers claim that only 6-7% of the crop is sprayed with daminozide. Some reports have suggested that heat treatment of apple juice converts daminozide into a more dangerous breakdown product. The British experts will have to make some critical judgments this week—balancing the known but small hazards of the current pesticides against the unknown risks of any new products or techniques developed to replace them.—TONY SMITH

Up to £50m for new consultant posts

The first of 100 new consultants promised in *Working for Patients* might be in post by the end of this year. Announcing this at a press conference last week, the Secretary of State stated that by accepting a share of out of hours responsibilities the new consultants would help to reduce junior doctors' hours of work.

Showing that the government is going to push ahead with proposals not requiring legislation, Mr Clarke has asked health authorities in England to bid, by the end of July, for new posts in a three year plan. These will be targeted at districts where four fifths of patients have waited for longer than a year in the specialties of general surgery; trauma and orthopaedics; ear, nose, and throat surgery; gynaecology; ophthalmology; and urology. Bids may also be made for other specialties in which authorities can show a problem for inpatient, outpatient, or day patient care. Authorities with long waiting times that do not bid will be asked what action they are taking to reduce waiting times.

Mr Clarke has asked the Joint Consultants Committee to advise on allocating the posts, which are above the government's commitment to expanding the number of consultants. The scheme provides for up to £500 000 a year for each new appointment, including the cost of extra nursing staff, extra medical staff in support services, and extra equipment.—LINDA BEECHAM

Two new reports on drunkenness

Each year in Britain about 100 000 people are arrested for drunkenness and 1000 are sent to prison for not paying drunkenness fines. Public drunkenness takes up at least 80 000 hours of police time each year, and the total cost to the criminal justice system is about £6·7m.

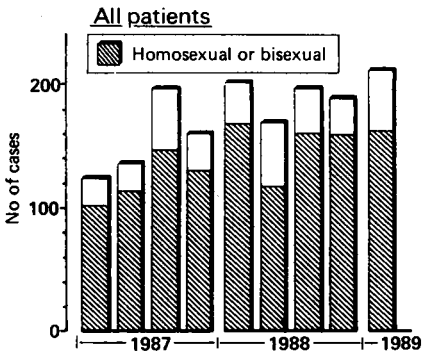
About a fifth of the offences are committed by people under 21, and convictions of those under 21 rose from 1852 in 1964 to 5825 in 1985. Much public concern about drunkenness among young people is concentrated on "lager louts" causing "rural violence," but a report published last week from the Home Office makes clear that much of the "rural violence" occurs in areas like the Slough triangle, the Medway towns, the Thames Valley, and Havant, which "are among the most densely settled areas in Europe."

But over 90% of the violent incidents that do occur in these "non-metropolitan areas" are associated with alcohol, and the incidents are clustered around the time when pubs close. The report shows that about a third of 16 and 17 year olds in these areas are going to the pub on Friday and Saturday nights and that some are drinking enormous amounts: 10% of a sample of 16-24 year olds in

AIDS update

The rate of increase in new cases of AIDS has slowed down: "doubling time" is now about 18 months compared with 12 months this time last year. The number of new cases among homosexual and bisexual men has remained steady for the past year. All but eight heterosexuals with AIDS but no established risk factors have either had partners with established risk factors or been exposed to infection abroad. More cases of AIDS are expected in the next 12-24 months among Scotland's HIV positive intravenous drug abusers, many of whom became infected in 1983-4.

New cases reported 1987-9 (quarterly)



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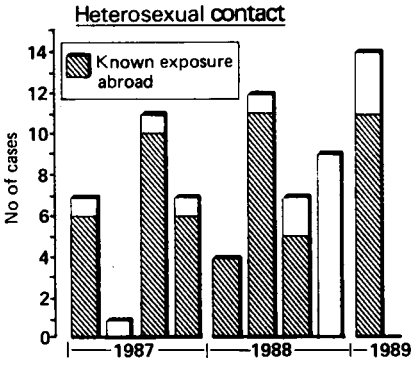

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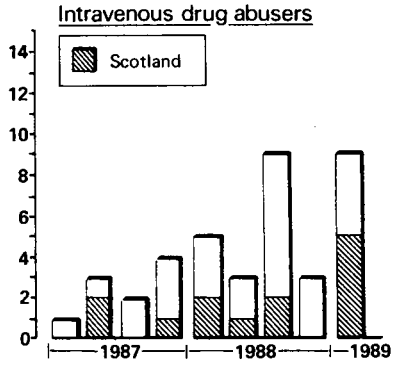


Cases of AIDS in the United Kingdom by patient characteristics (cumulative totals up to end of March 1989)

	Men (n=2112)	Women (n=80)	Total (n=2192)	Deaths (n=1149)
Homosexual or bisexual	1796		1796	932
Intravenous drug abuser	35	13	48	22
Homosexual and drug abuser	33		33	15
Haemophiliac	136	2	138	84
Recipient of blood:				
Abroad	10	13	23	15
United Kingdom	12	5	17	14
Heterosexual contact:				
Partner(s) with above risk factors	5	12	17	7
Others:				
With known exposure abroad	46	19	65	28
With no evidence of exposure abroad	6	2	8	6
Child of at risk or infected parent	9	12	21	10
Other or undetermined	24	2	26	16

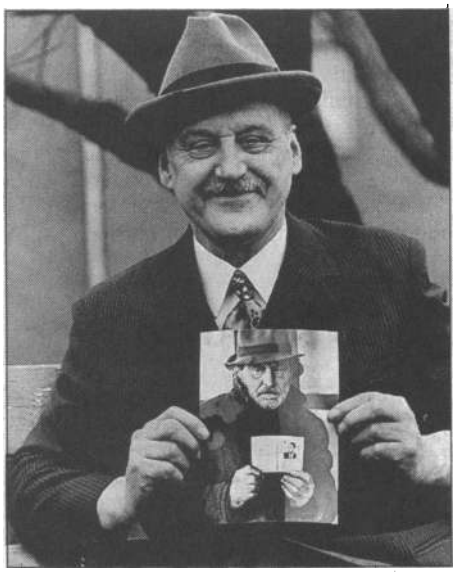
Prepared from direct voluntary confidential reports by clinicians to the PHLS Communicable Diseases Surveillance Centre (01 200 6868) and the Communicable Diseases (Scotland) Unit (041 946 7120).

Guildford and Surrey drank more than 17 units (8·5 pints of beer) on a Saturday night.

Only a few of these young people become violent, but those who do are more likely to have unskilled jobs or be unemployed and to have left school at 16. Much of the violence occurs around fast food outlets, and the report suggests that more could be done by planning authorities, brewery managers, and managers of fast food chains to avoid "congestion sites." The report also suggests increasing the availability of low alcohol and non-alcoholic drinks in pubs, staggering pub closing hours, and using identity cards to reduce under age drinking. John Wakeham, chairman of the ministerial group on alcohol misuse, has welcomed the report and plans to discuss it with representatives of the drinks and fast food industries.

Public concern is much less about another category of offenders—that of habitual drunken offenders. These are defined as those who are arrested three or more times a year for drunkenness, and a report published earlier this week estimates that there are over 10 000 such people in Britain. Many are homeless and have considerable social and health problems, and, says the report, their numbers are likely to increase because of government policies on homelessness and the increased availability of alcohol together with its reduced real price.

The report comes from Out of Court, an umbrella group of over 20 organisations formed in 1981 to divert habitual drunken offenders from the penal system. Dr Douglas Acres, chairman of the group, points out that "It is now 17 years since the government published its report on habitual drunken offenders, and . . . little has been done either to implement the most basic recommendations of the report or to deal effectively with those who are repeatedly convicted for drunkenness offences." The report analyses the failure of responses like detoxification centres, wet shelters, and the cautioning scheme and pins its faith on community drying out centres, "which will provide a safe and humane place for sobering up and act as a link between the problem drinker and an appropriate helping agency." There are plans for such centres in more than 10 British cities, "but all face the daunting hurdle of finding local funding."



WHO

Some habitual drunken offenders may "bloom" when effectively dried out and rehabilitated. (Picture reproduced from Health for All—All for Health international photo competition)

The NHS, says the report, will have to accept some responsibility for dealing with drunkenness offenders but at the moment shies away. Alcohol treatment units tend to offer treatment to a highly selected group that often does not include habitual offenders, while offenders, who are often homeless, may not come into contact with general practitioners. Specialist teams for the homeless—as operate in Camden and Tower Hamlets—are one solution, but better, says the report, is a scheme at the Middlesex Hospital that uses an alcohol liaison officer to link habitual offenders seen in casualty to outside helping agencies.—RICHARD SMITH

Tuck M. *Drinking and Disorder: a Study of Non-Metropolitan Violence* (Home Office research study 108). Available from HMSO, price £7.20.

Out of Court. *Drunkenness Offenders: the State of the Nation.* Available from the Secretariat, Action on Alcohol Abuse, Livingstone House, 11 Carteret Street, London SW1 9DL.

Medicines Control Agency

Dr Keith Jones became the first director of the Medicines Control Agency on 1 April. Dr Jones has worked for Merck Sharp and Dohme Research Laboratories in New Jersey since 1979 and for the past three years has been the executive director responsible for clinical pharmacology.

In 1988 the government decided to act on the recommendations in a report of an independent study of the medicines division of the Department of Health, which had been set up because of concern over delays in deciding on licence applications. The report recommended that the division should be reorganised under one director and that the cost of the organisation should be met from the licence fees paid by pharmaceutical companies. The new agency is responsible for ensuring that medicines available in Britain are safe, effective, and of satisfactory quality.

Keith Jones

A spectacle of spectacles

The history of spectacles from the fifteenth to the nineteenth centuries is recorded in an exhibition mounted at London's Guildhall Library to mark the centenary of the Carl Zeiss Foundation.

The exhibition features 200 eyeglasses and prints from the foundation's collection. There are 77 engravings, prints, and drawings of spectacles and their wearers, often with humorous touches. The illustration shows a 1650 etching by Rembrandt entitled *The Nail Cutter.*

The exhibition is open between 9 30 am and 4 30 pm Mondays to Fridays until 10 June, when it will transfer to Liverpool's National Museums.

ZEISS MUSEUM

Many a mickle

There are not many millionaires among patients with mental illness, but collectively they are surprisingly rich. An astonishing £66m of accumulated pocket money and other savings is being held in personal accounts on their behalf by the NHS. Long stay patients get £8.47 pocket money a week in lieu of income support or pension. They can also receive gifts and legacies. What they do not spend is invested for them in National Savings or building society accounts. The £66m represents this total plus compound interest.

All this came to light last week at the Commons select committee on the parliamentary commissioner. The health service ombudsman, Sir Anthony Barrowclough, had challenged a health authority's right to raid a patient's £500 savings to purchase clothing for him. For the Department of Health Mr Alan Bacon agreed that it was patients' money and that hospitals should not use it in substitution for public funds. It could be a breach of the law about trustees.

Sir Donald Wilson, chairman of Mersey Regional Health Authority, said that he

had no idea of the magnitude of the sums concerned. He was sure that other regional chairmen would like to make an offer to spend the money in the interests of the patients, and he proposed canvassing them for "innovative ideas" by way of amenities or recreation. — JOHN WARDEN

Correction

Economics of prescribing

An editorial error occurred in this news item by Stella Lowry (15 April, p 981). The correct cost of the report *Generic Pharmaceuticals—The Threat. Products and Companies at Risk* is £950 and not £9.50 as published.

The cost of protecting children

The National Society for the Prevention of Cruelty to Children helped over 48 000 children last year, with serious cases taking up an increasing percentage of the work. The society's annual report published last week shows that the number of referrals because of sexual abuse increased 24% in 1987-8, but the society sees this as encouraging. "The worst fears had been that worry, confusion, and doubt over what to do for the best would mean that concerns would be kept silent," said Dr Alan Gilmour, the society's director.

The Cleveland inquiry generated much public anxiety, and in the past year the society has distributed nearly two million copies of its booklet *Protect Your Child*, which gives information about child abuse, especially sexual abuse. The society increased its spending by about £3·7m last year; spending on direct services to abused children increased by 22%, and an extra 31% was spent on increasing public and professional awareness of child abuse issues, 47% on training, and 63% on planning and research. But despite a 13% increase in voluntary contributions in 1987-8 the society ended the year with a deficit of more than £3m.

Letter from Westminster

GPs make MPs bristle

The politicians are biting back. Doctors who write in anger to Conservative MPs should be warned to expect a reply in the same vein. Sadly, another ritual war has broken out between general practitioners and MPs, but the antagonism need not be taken as personal. They are firing above each others' heads—the doctors at the government, the Tories at the BMA. Neither high command is likely to yield.

In this skirmish between their opposing infantries my dispatch is from behind the Westminster lines. The banner to which the MPs rally is a Commons motion which 27 Conservatives had signed in the first two days. To reflect their feeling on the subject I quote it in full:

This House regrets that the BMA, which resisted the establishment of the National Health Service in 1947 of which it now claims to be the guardian, has not used the normal negotiating procedures to make its views known about the government white paper, *Working for Patients*, to the Department of Health; further regrets that in its extensive advertising campaign the BMA is using general practitioners' surgeries to present a biased view of the white paper; and questions the morality and ethics of an approach which is causing grave and unnecessary worry to very many elderly people when visiting their doctor.

Signatories to the motion tap the Tory reservoir at every depth from wet to dry. They include Mr Roger Sims (Chislehurst), a member of the social services select committee. He is telling his general practitioners that it is unprofessional and irresponsible to spread misleading information. Mr Robert McCrindle (Brentwood and Ongar), no whips' catspaw, replies to the effect that he resents his constituents being subjected to "black propaganda" in the consulting room.

These reactions typify Tory impatience with blanket rejection of the white paper or assertions that the NHS is being dismantled for privatisation. That approach is not going to dent the Conservative majority. But I detect a paradox in the Tory mood. While MPs instinctively don armour against the BMA they are all for donning kid gloves when it comes to handling what they consider to be genuine anxieties of their local general practitioners. It comes down to timing and technique. In this fight the rapier is going to be more effective than the ramrod.

Friendly view of white paper

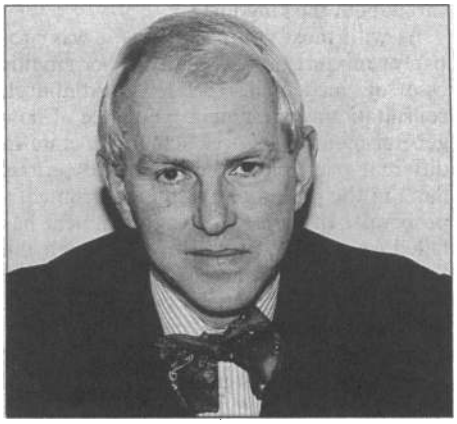
Signs that we may soon be entering the next phase were detected in what David Mellor, the Minister for Health, said last week about the white paper not being written on tablets of stone (p 1056). At the same time the social services committee adjusted to a friendly view of the white paper from the National Association of Health Authorities (NAHA).

Mr Martyn Long of the Mid-Downs Health Authority, who is chairman of NAHA, was bullish about the government's plan: "I don't think it will be the doom and gloom that has been predicted. I think there is a great deal of benefit for patients."

Mr Long relished the prospect of district health authorities being able to contract out their hospital services. He believed that it would be better when the authorities became the funders and not providers of direct services. They would be able to monitor quality control more strictly. "At the moment we are judge and jury over what we do," he said. "If you separate these roles it is much easier to have a funding organisation which puts more emphasis on making sure we not only get value for money but quality of service for the patients."

Mr Long was not put off by criticism that the changes were being made at breakneck speed. Rather than perfection from the start in two years it would be an evolving pattern, he said. Instead of exact costs of treatment there would be block costs, and the process would become more sophisticated as time went by. The service could rely on vast areas of experience and knowledge already gained.

The NAHA witnesses were more cautious about general practitioner budgets, agreeing that they might limit patients' choice if doctors entered into block contracts with only one or two hospitals. They also feared that clinical teaching and research could be adversely affected.



The chairman of NAHA, Mr Martyn Long, was bullish about the government's plans

Key to unlock the Treasury

An informed guess about what the white paper proposals would cost was attempted by Mr Tom Jones, director of finance of Herefordshire Health Authority. He estimated the extra resources at "well in excess of 2%" and maintained thereafter. Mr Long, however, was optimistic that when the NHS knew the cost of everything it would have the key to unlock the Treasury. "We would be able to say, 'Here is the proof that we need more resources,' instead of the tendency to throw money at the fan and hope it lands in the right places," he said. "When we know what our costs are it will be very difficult for government to resist funding the increasing needs of the elderly and the rest."

A postscript to the column on MPs' health (8 April, p 913). It was incomplete without a reference to the medical surveillance service for MPs, which is run by Dr David Snashall, consultant occupational physician at St Thomas's Hospital, London, with the help of a full time occupational health nurse. Its purpose is to give MPs an assessment of their own state of health so that they can take whatever action they choose. — JOHN WARDEN

Tartan tinged contract for Scotland's GPs

What did the government hope to achieve by offering a tartan tinged contract to Scotland's general practitioners (p 1105)? Was it a pragmatic response to the medical consequences of Scotland's geography and urban deprivation? Were Scotland's ministers, Malcolm Rifkind and Michael Forsyth, panicked into conducting a damage limitation exercise when they realised that Kenneth Clarke's London planned contract could spell disaster for Scotland's general medical services? Or did ministers see this as an opportunity to tempt Scotland's general practitioners to swallow the new contract whole and so break the near unanimous opposition to the government's proposals among general practitioners throughout the kingdom?

As with most political events it was probably a mixture of these motives, born in this case of inadequate Whitehall/Edinburgh consultation, government ignorance of how general medical services actually operate in different parts of the country, and serious flaws in the philosophy of the government's proposals. In the event the government has failed to split the profession. Although the Scottish General Medical Services Committee and the BMA's Scottish council last week cautiously welcomed the concessions as reducing the likely damage of the new contract in Scotland, they reiterated their opposition to its unchanged main principles. They were adamant, too, that negotiations had to be continued on a United Kingdom basis: there could be no separate Scottish deal.

No separate contract for Scotland

To emphasise this point Dr Michael Wilson, chairman of the General Medical Services Committee, who attended the Scottish GMSC's meeting on 13 April, invited its chairman, Dr M J Illingworth, to join the GMSC's contract negotiating team in London. Despite the sustained political pressure he is under Dr Wilson gave an impressively cool and measured analysis of developments on the contract negotiations with the government. Would that ministers could adopt a similarly restrained approach in their public utterances. Unfortunately, in the weekend press in Scotland Mr Forsyth, health minister at New St Andrew's House (Scotland's equivalent of Whitehall), resumed attacks on the profession, criticising general practitioners for failing to understand the contract. He claimed that he was horrified at their lack of knowledge at a fundamental level, a view prompted no doubt by the hostile reception he had received at a midweek conference of general practitioners which included some sharp criticism from the BMA's treasurer, Dr Alastair Riddell.

The Sunday papers also reported that the response of the Scottish GMSC and council had dashed the Scottish Office's hopes for a separate contract, with ministers accusing the BMA's medicopoliticians of misleading doctors by their instant reactions. Mr Forsyth is sending a leaflet to all Scotland's general practitioners setting the—or, more correctly, his—record straight and pointing out the opportunities that he sees the new contract offering them.

I always said that the going would get really rough in this dispute, and the BMA's success in public relations north and south of the border is clearly needling the government as can be seen by attacks on the "doctors' union" by Conservative MPs responding to public and professional criticisms of Kenneth Clarke's proposals for the new contract and the new competitive NHS. Had ministers been attending the Scottish GMSC and council they would perhaps have realised that the medicopoliticians' response was anything but instant.

Effect on patient care

I was struck by the moderation and care with which members dissected the new contract, their prime worry being its effects on patient care. I for one found it instructive to hear exactly what the proposals could mean for general medical services from doctors who had—so far as was possible in the absence of meaningful figures—worked out the consequences.

Dr P Dolan from the highlands reported that he had calculated that the effect of the unamended contract on his part of Scotland could have led to the loss of 25 or more doctors because the proposed qualifying list size for the basic practice allowance was well above the average list size in his area and would have made many practices uneconomic. I realised then why Scottish ministers had panicked as the implications dawned on them back in February.

Eight weeks of anxious consultation between New St Andrew's House and Richmond Terrace (the Whitehall headquarters of the Department of Health) resulted in nine modifications to the original contract. Among the tartan concessions are:

- Continuation of the rural practice fund
- A basic practice allowance based on average list sizes in a practice and payable for the first 1200 patients (but not below 400) with a specifically Scottish weighting to the supplementary allowance for deprived areas
- Possible staging arrangements for immunisation and cervical cytology screening targets
- An allowance for shared "associate general practitioners" to help singlehanded doctors in very isolated areas
- The possible inclusion of home visiting time in the qualifying 20 hours a week of direct consultation with patients.

Speakers at the Scottish GMSC and at the preceding day's council meeting saw these concessions as reducing the adverse effects of the new contract on Scotland's doctors and patients. Nevertheless, there were reservations that even those changes would still make the new contract uneconomic for many practices. One doctor forecast that 30% of his colleagues in his country town would be adversely affected. All speakers were adamant that the increase in the qualifying list size for the basic practice allowance and the increased administration would reduce the amount of time that doctors could spend with patients. There was widespread agreement, too, that the target figures for immunisation and cervical cytology screening were unrealistic for most practices. They could well lead to a fall in the number of children immunised and women screened because doctors would be disillusioned at facing unachievable targets.

Concern was also voiced about the effects on teaching students and vocational trainees because principals would have less time in which to do this essential work. Many general practitioners in Scotland work in small hospitals, and several committee members whose constituents did such work pointed out that no account had been taken of this in the proposed contract.

Ironically, one of the more optimistic speakers at the Scottish GMSC meeting was Dr Michael Wilson—though not in a way that would bring joy to ministers' hearts. He saw the concessions in the Scottish contract as pointing the way to similar concessions in England and Wales, some areas of which have problems akin to those in Scotland. Nevertheless, at the first reading doctors' representatives in Scotland remain resolutely opposed to the main thrust of the new contract—the greater proportion of remuneration based on the capitation fee and the more stringent criteria for the basic practice allowance—on the grounds that it will lower the quality of care for patients.

RCGP overwhelmingly opposes NHS changes

To add to that setback from Scotland ministers now have to face the galling fact that the Royal College of General Practitioners has lined up with the BMA and other royal colleges in opposing the government's proposals for change in the NHS. At a council meeting of the RCGP over the weekend members overwhelmingly concluded that if implemented as proposed the changes "will seriously damage patient care and the doctor/patient relationship." Ministers will now lose even more credibility if they continue to dismiss the BMA's opposition as a knee jerk trade union response.

SCRUTATOR