News

Ethics group rules on treating premature babies

Lynn Eaton *London*

Doctors should not normally give intensive care to premature babies born between 22 and 23 weeks' gestation, says a working party set up by the Nuffield Council on Bioethics.

The chances that these babies survive once they leave hospital are so low that such treatment is not appropriate, it argues.

"Natural instincts are to try to save all babies, even if the baby's chances of survival are low," said Margaret Brazier, the chairwoman of the working party and professor of law at Manchester University.

"However, we don't think it is always right to put a baby through the stress and pain of invasive treatment if the baby is unlikely to get any better and death is inevitable."

The new guidelines follow an increase in the number of extremely premature babies being born since the 1980s. Although the age at which such babies can survive has been falling, most will still die, says the report.

The council's consultation exercise has attracted a great deal of media attention as different organisations, such as the Royal College of Obstetricians and Gynaecologists, and the Church of England, have each submitted their evidence.

The council has summarised its guidelines in a table (right).

The guidelines say that only about 1% of babies born between 22 and 23 weeks' gestation survive to leave hospital. Intensive care should therefore be given only if the parents request it and then only after an exhaustive discussion of the risks—and if the doctor agrees.

"We believe that the guidelines will help parents and doctors to make decisions in these very traumatic situations," said Professor Brazier.

The council also says that the active ending of life of a newborn baby should not be allowed, no matter how serious the baby's condition. This, it says, would run the risk that the relationship between the parents and doctor would be "negatively affected."

"It would also be very difficult to identify an upper age limit beyond which actively ending life would not be allowed," the council adds.

The council endorses decisions either to withdraw treatment or not give it in the first place. But once these decisions are made, palliative care, including pain killers, should be given, it says. The NHS should train in palliative care all professionals working in neonatal medicine, it suggests, as knowledge and the use of techniques to make the baby as comfortable as possible vary considerably around the United Kingdom.

The council acknowledges that an increasing number of cases are coming to court, where doctors and parents can't agree on what treatment a premature very ill baby should receive. It recommends getting a second medical opinion, through a clinical ethics committee or professional mediation, to help reduce the number of these cases.

The council also calls for a code of practice to cover what should happen when a fetus of 22-24 weeks is aborted because of substantial risk of serious handicap. Usually feticide is done before the abortion to ensure the baby is not born alive, but if a woman does not want this the doctor may feel legally obliged to try to save the child if it shows signs of life when born.

The report points out that there is no legal requirement to give treatment if the baby has no hope of survival or if the level of suffering outweighs their interest in continuing to live.

It also calls for a more consistent approach to the support given to families with disabled children, but it acknowledges that prematurity accounts for only a small proportion of the total number of babies born with disabilities.

And doctors' decisions, it says, should be based on the best interests of the baby rather than concerns over resources.

Andy Cole, chief executive of Bliss, the premature baby charity, welcomed the initiative: "While only a small percentage of infants in the UK are born at 24 weeks or less, it is essential that every baby should be treated as an individual and given the best and most appropriate care at the point of life," he said. □

The report, *Critical Care Decisions in Fetal and Neonatal Medicine: Ethical Issues*, is available at www.nuffieldbioethics.org.

The guidelines at a glance*

Premature birth (weeks)	Likely outcome†	Recommended action
22-23	Only 1% are likely to survive	Do not give intensive care unless parents request it, then only after full discussion of risks and with the doctor's agreement
23-24	11% are likely to survive, but predicting whether they will live, die, be healthy, or have disabilities later is difficult. The EPICure study shows two thirds had moderate to severe disabilities	Parents, after a thorough discussion with the healthcare team, should have the final say over whether intensive care is given
24-25	26% are likely to survive	Give intensive care unless the parents and doctors agree there is no hope of survival or the level of suffering outweighs the baby's interest in continuing to live
>25	The baby has a sufficiently high chance of surviving (44% at 25 weeks) and low risk of developing severe disability (two thirds have no or only mild disabilities)	Intensive care should normally be given

*Active ending of life is not allowed no matter how serious the condition. Where a decision has been made to withdraw treatment, palliative care, including pain relief, should be given.

†Survival rates are based on Costeloe K, Hennessy E, Gibson AT, Marlow N, Wilkinson AR and the EPICure study group. The EPICure study: outcomes to discharge from hospital for babies born at the threshold of viability. *Pediatrics* 2000;106:659-71.

In brief

Survey supports anonymity of donors: More than half (58%) of the respondents to a survey by YouGov support egg and sperm donors' right to remain anonymous. The survey, for the UK charity Progress Educational Trust, comes a year and a half after the law changed in April 2005, removing anonymity for donors. However, sperm donations rose from 133 in April-October 2004 to 143 for the same period in 2005. Egg donations fell from 625 to 509.

Israel allows right to die: An Israeli law that allows people who are terminally ill to die in dignity, rather than be kept alive against their will, will come into effect on 15 December. Doctors will openly carry out the living wills, which will be stored in a national database. A timer with a delayed response could automatically turn off a patient's respirator in a small minority of cases.

Parkinson's disease set to increase: The number of people older than 50 years with Parkinson's disease in the five most populated countries in western Europe and the 10 most populated nations in the world will double from between 4.1 and 4.6 million in 2005 to between 8.7 and 9.3 million by 2030, according to projections in *Neurology* (2006 Nov 2, doi: 10.1212/01.wnl.0000247740.47 66 7.03).

Gender doctor case adjourned: The General Medical Council's hearing on Dr Russell Reid, a gender disorder specialist accused of ignoring guidelines and hurrying patients into sex change surgery, has been adjourned until late February. The defence had argued for dismissal after the case's allotted time ran out last week, but the motion was dismissed.

Australian doctors call for shorter hours: the Australian Medical Association reported last week that despite a fall in long shifts for hospital doctors, some were still working continuous shifts of 39 hours. The association said that such hours were unacceptable. See www.ama.com.au/

US health industry to set safety guides for hospitals

Janice Hopkins Tanne *New York*

A consortium of government and private groups working with the US National Quality Forum will soon issue a set of 30 "safe practices" that hospitals should use to reduce medical errors and prevent patient injuries and deaths.

The "safe practices" will give hospitals uniform guidelines to improve patient safety. The forum will also help hospitals implement them. The comment period on the practices ended this week.

The guidelines are important because hospitals that use them are likely to be preferred by consumers and government and private health insurance plans. Hospitals that do not comply might lose accreditation and reimbursement by government and private insurers, the *Wall Street Journal* reported (Nov 1 2006, http://online.wsj.com/article/SB116234626074809703.html)

The "safe practices" are a response to the Institute of Medicine's 2000 report, *To Err Is Human*, which estimated that up to 100 000 US citizens died each year because of medical errors. Since then, many groups have worked to improve patient safety, including the organisers of the "100 000 lives" campaign, led by Harvard's Donald Berwick and colleagues (*BMJ* 2006;332:1328-30 and 1468).

The US National Quality Forum, a leading government advisory group, represents groups of consumers, employers, health professionals, insurance plans, and labour unions. In 2003 it endorsed a set of 30 safe practices that it recommended for use in all healthcare settings to reduce harm to patients.

The latest guidelines include three new practices, 23 practices from the 2003 list that have been modified, and four practices that remain unchanged. (www.qualityforum.org)

Some practices are general, such as "create and sustain a healthcare culture of safety." Others are more specific. The guidelines recommend that healthcare professionals tell patients, and their families if appropriate, of "serious, unanticipated outcomes."

When patients are asked to consent to procedures or treatments, a healthcare worker must also ask them to repeat back the information to make sure they understand. Likewise, healthcare staff receiving verbal or telephone orders or reports are to be asked to repeat the orders back to ensure accuracy.

Dutch insurers pay midwives to refer fewer to hospital

Tony Sheldon *Utrecht*

SATURN STILLS/SPL

Doctors say that midwives should not be under financial pressure to perform external cephalic versions in home settings

Gynaecologists in the Netherlands fear that women could have more complications in childbirth because of a contract between health insurers and midwives that offers financial incentives to reduce expensive referrals to hospital.

The contract promotes the use, in primary care, of external cephalic version. If unsuccessful then women could be referred to hospital. This approach aims to reverse a trend towards caesarean sections.

The Dutch Association for Obstetrics and Gynaecology says that external cephalic version should be offered by hospital gynaecologists in a clinical setting, however. It fears that offering financial incentives to keep pregnant women away from specialist care "puts a bomb under the quality of obstetric care."

The contract signed between the umbrella group for the healthcare insurance sector, Zorgverzekeraars Nederland, and the Dutch Organisation of Midwives sets targets to reduce the number of breech presentations at birth by 400 this year, increasing to a total of 1400 in 2008. This, it claims, will translate into fewer caesarean sections, at a saving of £4.35m (€6.47m; $8.32m).

In return the midwives' organisation receives up to £660 000 a year to promote quality in care through research; setting guidelines; and training in treatments, such as doing external version.

The obstetrics and gynaecology association believes that all women with complications in pregnancy, including the 3% to 4% of those with a breech presentation, should be referred to a hospital gynaecologist. Its president, Jan Nijhuis, professor in obstetrics at Maastricht University Hospital, argues that no scientific evidence indicates that external version would be more successful if done by a midwife in a home setting and that there are greater dangers associated with complications of external cephalic version if done at home.

Royal College of Surgeons give approval for face transplants

Adrian O'Dowd *London*

Surgeons' leaders have given a cautious go ahead for doctors to carry out face transplants, providing that they follow stringent requirements.

A report published this week by the Royal College of Surgeons of England said that matters had moved on considerably in the three years since the college last spoke on the issue and rejected the idea.

The college has decided that, despite many reservations, it is permissible to proceed with caution, and spelt out 15 minimum requirements that should be met.

These cover medical and technical skills, psychological considerations, resources, and social issues. All the requirements must be met before the college will give its approval to patients who want to take what the report called a "leap in the dark" by having such a transplant.

The requirements include:

- The surgical unit has sufficient technical skill and experience
- A comprehensive and coherent protocol for selecting suitable patients
- The hospital's or institution's research ethics committee protocol provides potential patients with adequate information for valid informed consent
- A guarantee that the transplant and psychological teams and the hospital can provide long term funding to ensure that all patients continue to receive the care and support they need.

Peter Morris, chairman of the working party that produced the report and a former president of the college, said that since the college's last report in 2003 on this issue, successful face transplants had taken place, and a UK surgeon had been given permission by his trust to undertake them in the future.

"As a result of that, we have changed our position," he told a press conference. "Now we think that, provided minimum requirements are satisfied, we now find it would not be inappropriate for an appropriately constituted ethical committee to give permission for facial transplantation to proceed."

When asked whether the plans for face transplants at the Royal Free Hospital in London that were announced recently would meet the college's 15 requirements, Professor Morris said: "That we can't say because we haven't seen the protocols from its ethics committee.

"We would hope that in long term preparation being made, they will meet most of the requirements that we have outlined."

Peter Butler, consultant plastic surgeon at the Royal Free Hospital, who will carry out the transplants, said later that the requirements were in line with evidence that he had submitted to the college in preparation for the report.

"We will meet all of the college's requirements. Indeed, we suggested there be minimum standards as the way forward," he said.

The working party's greatest reservations, added Professor Morris, were over the consequences of long term immunosuppression, the risks of acute and chronic rejection, and psychological and ethical aspects.

The *Facial Transplantation: Working Party Report* is available at www.rcseng.ac.uk/publications/docs/facial_transplant_report_2006.html

MICHEL SPINGLER/PA/EMPICS

LEWIS WHYLD/PA/EMPICS

Isabelle Dinoire (left), underwent the world's first face transplant in France in November 2005, while Peter Butler plans to conduct the first UK operation at the Royal Free Hospital

GMC strikes off expert in drug addiction

Owen Dyer *London*

An expert in drug addiction who is viewed by some as a pioneer in his field has been struck off by the UK General Medical Council after a case lasting almost three years (*BMJ* 2004;328:483).

Colin Brewer, the former medical director of the private Stapleford Centre Addiction Treatment Clinic, was the only one of seven doctors from the clinic to lose his right to practise.

Two other doctors from the clinic were also found guilty of serious professional misconduct. Ronald Tovey had conditions imposed on his registration, and Hugh Kindness received a reprimand. Charges against four other doctors from the clinic were found not proved in 2005.

The Stapleford case has been the longest and most complicated in the history of the GMC. The panel sat for 82 days and examined more than 1500 prescriptions.

Dr Brewer was found to have provided treatment that fell short of medical standards in the cases of 13 patients. In the most serious case, 29 year old Grant Smith died while using a home detoxification kit that contained 16 different drugs. His mother, who was supervising the treatment, said that she had been unaware of the need to watch her son even while he slept. The GMC panel found the instructions for the kit confusing and unclear.

Other shortcomings noted by the panel included Dr Brewer's failure to do an adequate initial assessment or dose assessment; failure to maintain adequate contact with patients or to monitor compliance; and failure to notify patients' general practitioners or refer patients for other medical conditions. Dr Brewer was also found to have prescribed opiates for pain without considering the underlying condition.

Prescriptions at the clinic were often large, allowing a potential for diversion. One patient's prescriptions were collected on 34 occasions by six different people, some of whom were known addicts.

Dr Brewer also ignored warnings in the *British National Formulary* about the use of several drugs that are now considered dangerous or addictive, such as dexamfetamine, barbiturates, dextromoramide, and flunitrazepam (Rohypnol).

Dr Brewer took over the Stapleford Centre, which has branches in Essex and Belgravia, London, at the request of the Home Office in 1987 after the clinic's previous director was found guilty of overprescribing. He earned a reputation as an innovator, pioneering the use of naltrexone in opiate withdrawal and developing for the Home Office a successful programme to treat drug addiction in prisons.

Denis McDevitt, chairing the GMC's fitness to practise panel, told Dr Brewer, "You brought to the treatment of drug addicts a clinical concern and interest that does not always appear to be a feature of their treatment by others. You have practised outside established guidelines because you have considered, rightly, in some instances, that this was in the best interests of your patients."

But Dr Brewer had grown overconfident and dismissive of other views, he said, and had placed too much trust in patients.

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GMC hears parents' complaints about Southall

The paediatrician David Southall faced fresh charges before the General Medical Council this week over his investigations of parents whom he suspected of harming their children.

Professor Southall adopted the role of "detective or crown prosecutor" when interviewing the mother of a 10 year old boy who had been found hanging in his bedroom, alleged the GMC's counsel Richard Tyson QC. The GMC's charges allege that Professor Southall accused the woman of drugging and hanging her son, adding to the distress of a bereaved parent.

The boy, identified only as M1, died in June 1996, and his inquest ended in an open verdict. His mother, named only as Mrs M, was later referred to Professor Southall by social workers concerned about the welfare of her second son, M2.

In January 1998 Professor Southall advised the local authority that he believed Mrs M had Munchausen syndrome by proxy. Professor Southall's initial findings led the local authority to take M2 into care.

While preparing a report for care proceedings, he interviewed Mrs M in April 1998.

Speaking by video link from Australia, Mrs M told the hearing that Professor Southall had been "very aggressive and sarcastic."

The current hearing concerns complaints from four other families.

Owen Dyer *London*

CMO's plans for undergraduate education are attacked

The debate about who should take responsibility for undergraduate medical education continued this week as the Royal College of Surgeons of England and the body that the chief medical officer favours for the role both agreed that a transfer may not offer any advantages over the current regulator.

At present the General Medical Council is responsible for setting the medical undergraduate curriculum and approving medical schools. However, in his review of medical regulation published in July (*BMJ* 2006;333:163) the chief medical officer for England, Liam Donaldson, recommended that the Postgraduate Medical Education and Training Board (PMETB) should take over the role.

The board says it recognises the benefits of a single regulator but is concerned that the costs of the transfer may outweigh the benefits.

Meanwhile the Royal College of Surgeons of England has said it does not see the need for a change: "The case for handing responsibility to PMETB has not been made. PMETB already has a wide role and is a new body still in the early stages of implementing its current responsibilities."

Zosia Kmietowicz *London*

The responses of the PMETB and the Royal College of Surgeons of England can be seen at www.pmetb.org.uk/gooddoctors and www.rcseng.ac.uk/publications/docs/cmo_report_response_2006.html.

European health commissioner praises food firms for efforts to cut obesity

The European Commission has publicly praised some of the world's most famous food and drink companies for voluntarily taking measures to tackle obesity as part of the European Union's wider strategy to promote healthy diets.

At an awards ceremony in Brussels, Markos Kyprianou, the public health commissioner, called on other manufacturers to follow the examples set by Coca-Cola, PepsiCo, McDonald's, Unilever, and Kraft Foods. And he rejected suggestions that the independent institution was flirting with commercialism.

"You have to acknowledge positive steps, and I challenge other parts of the industry to do the same," he said.

Nine large soft drinks companies grouped in the Union of European Beverages Associations have pledged not to advertise their products to children under 12 years old.

McDonald's has developed bar charts that give customers guidelines on the amounts of energy, protein, fat, carbohydrates, and salt contained in different types of food. The information is available in the fast food chain's 6300 outlets in Europe and will be present in its 20 000 restaurants worldwide by the end of the year.

Rory Watson *Brussels*

Indian activists say drug price cuts are a ploy

Some of India's largest drug companies have reduced the prices of 886 drug formulations, but health activists and some doctors have described the move as a ploy by the drug industry to evade meaningful price control.

The government last week released a list of formulations for which the drug companies have voluntarily reduced the prices by amounts ranging from 0.26% to 74% below current prices.

Officials at the Indian Ministry of Chemicals have said that the 11 companies submitted individual lists in response to ongoing government initiatives to work with industry to reduce the retail price of drugs.

The formulations cover many classes of drugs, including analgesics, antibiotics, antihypertensives, antipsychotics, and vitamins. But health activists have criticised the list, saying that it creates a misleading impression that the drug industry has made important concessions.

Pharmacology experts say that most of the drugs in the list are not prescribed by doctors but are sold through retail outlets. "None of the companies have reduced the prices of any of their top 20 drugs," said Chandra Gulhati, editor of the *Monthly Index of Medical Specialities* in India.

Ganapati Mudur *New Delhi*

Doha Declaration has failed to deliver cheap drugs, says Oxfam

Efforts to improve access to drugs for people living in poorer countries have failed despite a worldwide agreement designed to tackle the issue, it has been claimed.

Oxfam has published a report on the fifth anniversary of the Doha Declaration, and claims that little has changed and in some cases things have worsened since the agreement was made dealing with the trade related aspects of intellectual property rights (TRIPS).

The formal trade declaration, aimed at putting health before profits, has not worked, says the report, and in a debate held last week in London to coincide with the report launch, a motion saying "This house believes that the Doha Declaration delivered what is needed from TRIPS in terms of access to affordable medicines"

was overwhelmingly rejected.

All members of the World Trade Organisation signed up to the declaration in 2001, which asserted that intellectual property rules should not prevent countries from protecting public health.

Oxfam says that the behaviour of rich countries has "ranged from apathy and inaction to sheer determination to undermine the Doha Declaration."

Adrian O'Dowd *London*

Patents versus patients: five years after the Doha Declaration can be seen at www.oxfam.org.uk/what_we_do/issues/health/bp95_patents.htm

Charity demands better alcohol treatment services

Substantially better alcohol treatment services are needed if the United Kingdom is to curb mounting levels of drink related death and disease, a leading charity said this week.

Alcohol Concern is launching its campaign after a series of dismal reports in the past three months that have highlighted the scale of the problem facing Britain.

In October the Department of Health admitted that the number of patients requiring hospital treatment for alcohol related illness had risen by 50% in the past five years.

Last week the Office for National Statistics showed that mortality from chronic disease related to alcohol had almost doubled in the UK between 1991 and 2005, from 6.9 to 12.9 per 100 000.

The figures, putting alcohol related deaths at 8386 in 2005 were, however, "just the tip of the iceberg," Alcohol Concern's annual conference heard this week.

The charity is launching a national campaign to persuade the government and local health authorities to inject more cash into alcohol treatment services.

The Department of Health has found that only one person in 18 who needs help for alcohol misuse receives it (www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Alcohol Misuse/fs/en).

Michael Day *London*

The report, *Wasted: Lives Lost to Alcohol*, is available at www.alcoholconcern.org.uk.

High Court judge over-rules GMC decision not to pursue GP

A GP caught up in a newspaper "sting" over sick notes faces a new disciplinary hearing before the General Medical Council. A high court judge ruled last week that a GMC fitness to practise panel was wrong to stop an earlier hearing going ahead.

The case breaks new ground in establishing that the Council for Healthcare Regulatory Excellence, the watchdog on the regulation of health professionals, has the power to challenge decisions to stay proceedings against doctors accused of wrongdoing, not just acquittals and lenient penalties.

The fitness to practise panel imposed a stay last January on disciplinary proceedings against Gurpinder Saluja, from Walthamstow, east London, after ruling he had been "pressurised" by an undercover journalist who had entrapped him. The panel held that admitting a covert tape recording as evidence and allowing the case to go ahead would be an abuse of process.

But Mr Justice Goldring quashed the panel's decision, ruling that the case should go forward and, if appropriate, sanctions should be imposed.

Dr Saluja was one of several GPs selected at random and asked to provide a sickness certificate for a *Sunday Times* journalist, Rachel Dobson, who allegedly told him that she was not ill but wanted a holiday at Christmas.

It was alleged that when she said she could pay £1000 (€1500; $1900), Dr Saluja replied that he could not provide a certificate so far in advance but could guarantee to provide one a couple of days before she needed it, even though she might not be ill.

Clare Dyer *legal correspondent, BMJ*

Woman dies after doctors fail to intervene because of new abortion law in Nicaragua

Sophie Arie *Managua, Nicaragua*

A hospital in Nicaragua is investigating the death of a woman after doctors failed to intervene to save her life during complications in pregnancy.

It is suspected that doctors did not dare to carry out an abortion because a new law has been approved that bans all forms of abortion, whether a woman has been raped or risks death during pregnancy.

Under the law, women who terminate their pregnancies and doctors who carry out abortions will face up to 20 years in jail. Although the law has yet to be signed into effect by the country's conservative president, the fear of punishment already seems to be discouraging doctors from treating some women.

On 2 November, the young woman died at a Managua hospital after doctors failed to intervene to stop vaginal bleeding. Some doctors told local media they did not treat the woman for fear of breaking the law. The hospital is investigating why the woman was not treated properly.

Last week, a woman with heart problems in her 15th week of pregnancy was still waiting for a possible abortion at a hospital in the town of Masaya while doctors deliberated over the legality of treatment.

Deputies from the three main parties supported the law in a vote which took place just 10 days before presidential elections in which the country's former Marxist guerrilla leader, Daniel Ortega, was elected 16 years after his Sandinista government was voted out of power.

Ortega, now 60, whose 1979-80 Sandinista government clashed with senior members of the Catholic church, says that these days he is more Christian than Marxist.

Amid fear of losing the support of the church in the final stages of the election campaign, some 25 Sandinista deputies voted with conservative lawmakers for the abortion ban on 27 October.

The law, which overturned a 130 year old policy allowing "therapeutic" abortion, comes as some of the regions most conservative countries, such as Chile and Mexico, have begun to loosen their strict abortion laws under pressure to modernise.

"This is taking our country backwards," said Azahalea Solis of the Nicaraguan Women's Autonomous Movement. "Thousands of women could die because of this."

EDGARD GARRIDO/AP/EMPICS

Former guerrilla leader Daniel Ortega says that he is now more Christian than Marxist

Law to resolve small negligence claims gets royal assent

Clare Dyer *legal correspondent, BMJ*

Legislation paving the way for a fast track, low cost scheme to resolve clinical negligence claims up to £20 000 (€30 000; $38 000) in England without litigation received royal assent last week.

Under the new scheme, when something goes wrong with a patient's care, the hospital trust where it happened will do a fact finding exercise. Then the NHS Litigation Authority (NHSLA), which will run the scheme, will determine fault and decide what redress to offer. Compensation will be in line with awards made by the courts. Patients accepting an offer, which could include an apology, will waive their right to take court proceedings, but patients dissatisfied with the offer will still have a right to take civil action.

The NHS Redress Act passed into law after unsuccessful last minute attempts by Conservative and Liberal Democrat peers to push through an amendment providing for independent outsiders, rather than the staff of the NHS trust concerned, to do the fact finding investigation into what went wrong with a patient's care.

The legislation creates the framework, but the details of the redress are still to be worked out, and the scheme is not expected to be launched before April 2008. Next year a three month consultation period on the regulations will work out the details.

Based largely on the 2003 paper *Making Amends* from the chief medical officer for England, Liam Donaldson (*BMJ* 2003;327:7), the scheme is an attempt to cut legal costs which in 2004-5 came to £150m, nearly one third of the £500m paid out in clinical negligence cases.

Health minister Andy Burnham said the initial investigation into a medical mistake should be conducted by the trust where it happened

The scheme also aims to reduce delays, provide an explanation for the patient of what went wrong, and make it more likely that the NHS learns from its mistakes.

Only hospitals are covered, although the scheme could be extended later to primary care. It is not a no fault scheme and will pay out only if the NHS Litigation Authority is satisfied that the patient's care was negligent.

Critics argued that the process would not be independent if hospital trusts investigated their own complaints. And the Commons constitutional affairs committee was "concerned that if the organisation which is responsible for defending trusts and hospitals [the NHSLA] is also charged with running the scheme, there may be a perception (whatever the reality) of a conflict of interest."

The government has responded with some concessions while retaining the basic framework of the scheme. A government amendment will allow a report from a medical expert jointly instructed by both sides in some circumstances, the details of which are still to be worked out. In a further concession, patients will be entitled to see the full investigation reports on their cases.

Patients will be entitled to free legal advice on offers and settlements and on whether a joint medical expert is to be instructed.

Rejecting calls for an outside investigation, the health minister Andy Burnham told MPs, "To have an independent investigation at first stage would simply import into this scheme the same qualities that are available to patients should they not choose to pursue their complaint through the redress scheme but to go to law and litigation if they didn't receive satisfaction through this."

He said that the government did not favour an independent scheme, which would "lose the benefits of an NHS trust owning up to and being open about mistakes that have been made; learning from them; and making changes to prevent such things happening to other people."

The patients' charity Action Against Medical Accidents, which has lobbied for improvements to the scheme, gave the new legislation a guarded welcome and described it as a "wasted opportunity to do something radically different."

Peter Walsh, the charity's chief executive, said, "The challenge now is to make the scheme as robust and workable as possible by making sure that sensible regulations governing the scheme are adopted and working with bodies such as the Legal Services Commission [the body that grants legal aid] to ensure it does not inhibit rather than promote access to justice.

"If we do that, it will be a credible alternative for patients injured by the NHS to seek redress." □

Education and training is cut to achieve NHS savings

Susan Mayor *London*

Budgets for medical education and training are being cut as part of overall cost savings in the NHS in England, the BMA has warned in a letter sent to the health secretary this week.

Funding for medical education and training in England was ring fenced until April this year. But this was removed under arrangements allowing strategic health authorities to choose how to spend their budgets. Budget allowances announced recently by some strategic health authorities have much larger cuts in medical education and training than expected.

The BMA said that these cuts include substantial reductions in funding for junior doctors' study leave, which allows them to attend courses for their training.

In the letter to the health secretary, the BMA's Junior Doctors Committee warned: "The most notable example is in the South Central Strategic Health Authority area where some employers have, on the instruction of the [authority], cut [annual] study leave from £872 [$1600, €1300] per junior to £340, leaving no money for funding anything other than advanced life support courses for a small number of key staff."

The letter quoted the authority's explanation of these cuts, which stated: "The Department of Health has reduced these allocations to offset the predicted overspends in some parts of the NHS in England this year."

The BMA reported that several hospitals—including Southampton University NHS Trust, Sussex Partnership NHS Trust, and East Sussex Hospitals NHS Trust—have put claims for funding for study leave on hold after the budget cuts.

Jo Hilborne, chairman of the BMA's Junior Doctors Committee, said: "We are hearing more and more reports from junior doctors that they are not being allowed to take any more study leave this year.

"Cutting education and training as a quick fix to the financial problems facing the NHS is both demoralising to staff and potentially damaging to patient care."

A new direction for health?

Last week's victory for the Democratic party in the US mid-term elections is likely to mean changes in health care for senior citizens and uninsured people and less restriction on abortion, says **Janice Hopkins Tanne**

Now that the Democratic party controls both the House of Representatives and the Senate in the United States, changes may come affecting many national health issues when the new Congress takes charge in January.

The changes may include prescription drugs for elderly people, coverage for the 47 million US citizens without health insurance, reproductive health and abortion rights, and stem cell research.

Nancy Pelosi, a Democrat from liberal San Francisco, will become speaker of the House of Representatives. If the president, George Bush, and the vice president, Dick Cheney, were unable to serve, she would become president. It is the first time a woman has held this position.

FRANK FRANKLIN/PA/EMPICS

A victorious Hillary Clinton, who was re-elected senator for New York, told Associated Press this week: "Health is coming back"

Drug plans for elderly people

The Democratic majority wants to change the Medicare drug plan for older people, called Plan D. Medicare is the government's health insurance plan for US citizens aged 65 years or more. Last year elderly people had to enrol in Plan D to get prescription drugs at prices that were sometimes reduced or face penalties if they delayed.

The law that set up the Plan D programme prohibited Medicare from negotiating drug prices with drug companies, as the US Veterans Administration does.

Critics called Plan D a giveaway to the pharmaceutical industry. Many elderly people found it confusing to choose between plans—50 or more in each state—that offered different premiums and a different basket of drugs at different prices. Some of them couldn't evaluate the plans on the internet. And some complained that drug prices rose.

Ms Pelosi has said that in her first 100 hours in office she wants to pass legislation to allow Medicare to negotiate drug prices directly with drug companies. However, Michael Leavitt, secretary of health and human services, told the *New York Times* the administration would strongly oppose negotiating with drug companies (Nov 13, p A16).

Other healthcare issues

The Democrats probably want to introduce "pay for performance" for doctors and hospitals into Medicare, which pays for much US health care. The Democratic senator Edward Kennedy of Massachusetts will become chairman of the Senate committee overseeing health and is likely to consider legislation to implement standardised electronic health records and perhaps to overhaul the National Institutes of Health and the Food and Drug Administration, according to *CQ Today* (www.cq.com, 11 Nov 2006, "Election day 2006: a good day for health care").

The Democrats are unlikely to support President Bush's health savings accounts, in which people put aside money, tax-free, to pay routine medical bills while buying insurance policies that cover expensive treatments. The accounts are thought more useful for richer people and may discourage less wealthy people from paying out of their own pockets for ordinary care.

Coverage for uninsured people

About 47 million US citizens lack health insurance (*BMJ* 2006; 333:516). Many of these people delay seeking treatment for illness, they do not undergo preventive screening, and their uncompensated care is a drain on hospital budgets.

A national plan to cover them is unlikely. State plans may be expanded, however, to cover more children and to allow people in their 50s and early 60s to enrol in Medicare. If these people lose their jobs, they often can't find jobs that include health insurance.

Hillary Clinton, who proposed a national healthcare plan in the 1990s that came to nothing, was re-elected senator from New York, with a huge majority. She is a likely candidate for president in 2008. Health care is one of her interests, but she is likely to step more carefully this time.

Reproductive health and abortion

Voters in the conservative state of South Dakota rejected the state's ban on all abortions except to save the life of the woman. The ban had been passed by the state legislature, but voters signed a petition to place it on the ballot, and it was rejected 55% to 45% in the general election.

Restrictions on abortion, such as parental notification or pre-abortion counselling may remain in several states, although some states rejected such restrictions.

The day after the election, the Supreme Court heard oral arguments about the federal law banning "partial birth abortion," passed in 2003. The nine-justice court is now more conservative than when it legalised abortion in the case of Roe *v* Wade in 1973.

Obstetricians call the procedure "intact dilatation and extraction and evacuation" or "dilatation and extraction." It is used in only 1% to 2% of abortions.

The Planned Parenthood Foundation, the American Civil Liberties Union, and other plaintiffs said the law was unconstitutional because it had no provision to protect the health, rather than the life, of the mother, and that experts, such as the American College of Obstetricians and Gynecologists, said the definition was so vague as to frighten doctors away from using common procedures to end pre-viable pregnancies. The college also said this was sometimes the safest procedure.

The Department of Justice defended the government's position. US Solicitor General Paul Clement, said, "This is about something far closer to infanticide" (www.msnbc.com, 8 Nov 2006, "Supreme court: 'partial birth' drama").

The Supreme Court will issue its decision next year, probably by July.

Meanwhile, the emergency contraceptive Plan B went on sale in pharmacies. It is available on request to a pharmacist for women aged 18 years or older, but requires a prescription for younger women. Approval of Plan B by the FDA was delayed, criticised, and may have led to the resignation of FDA commissioner Lester Crawford (*BMJ* 2005; 333:461).

President Bush's White House was suspected in delaying Plan B's approval (*BMJ* 2006;333:317). The Center for Reproductive Rights was this week granted permission to subpoena White House documents as part of its lawsuit against the FDA's delay in approving Plan B.

Janice Hopkins Tanne *New York*

Who's using whom?

Will China gain influence from having one of its people at the head of WHO or will the winner be WHO itself as China becomes more engaged in fighting infectious disease? **Anne Glusker** reports

Dr Margaret Chan of China was elected last week to be the new director general of the World Health Organization. Chan, 59, a former public health minister of Hong Kong and, most recently, chief technical and administrative officer at WHO, won after rounds of secret balloting at the organisation's headquarters reduced the original field of 13 candidates to a shortlist of five and then to one opponent, Julio Frenk of Mexico. Chan won convincingly, with two thirds of the vote, the culmination of a campaign season marked by allegations of influence peddling.

Two main and interrelated questions shadowed Chan's campaign and will be the backdrop against which critics will watch her tenure unfold. One concerns her handling of the severe acute respiratory syndrome (SARS) and avian flu epidemics while she was Hong Kong public health minister; the other question involves her relationship with China.

Although some people believe that having Chan at the head of WHO will more fully integrate China into the world health community, making it more cooperative in future disease outbreaks; others scorn that notion, saying that China is using WHO strategically to raise its standing in world opinion.

Several actions by China during the SARS and avian flu crises raise questions about its behaviour and attendant questions about whether Chan has the wherewithal to stand up to the Chinese government, which supported her campaign. Jiang Yanyong of the People's Liberation Army General Hospital in 2003 exposed under-reporting of SARS and was then held under house arrest (*BMJ* 2004;329:130). In addition, China was not forthcoming in offering samples or information to WHO and others during avian flu outbreaks.

Kwok Ka-Ki, medical sector functional constituency representative of the Legislative Council of Hong Kong, said: "Her [Chan's] performance in the 1997 bird flu outbreak and the 2003 SARS outbreak was not impressive to the people of Hong Kong. She has played down the importance of both outbreaks. She was not particularly keen to alert the public and not particularly keen to dig out the facts."

Anders Nordström, acting director general of WHO, congratulates Margaret Chan on her election

PETER WILLIAMS/WHO

But, looking toward the future, Kwok added: "I hope her appointment will make China engage itself in the war against infectious disease. China is a likely source of infectious disease and an engaged China will be beneficial to the rest of the world."

Chan is the first Chinese person to head a large United Nations agency and the first Asian woman to head WHO. She is seen as a savvy political operator who managed to evade strong criticisms over lack of transparency while she was public health minister and then go on to a successful tenure at WHO as chief of communicable diseases.

Although some people doubt her ability to face down China, which strongly supported her campaign, she receives high marks as a capable and effective manager from those who have worked with her in Geneva headquarters. Because she got her medical degree from the University of Western Ontario in Canada, she has experience of Western attitudes. She emphasises this by saying, "I no longer carry my nationality on my sleeves. I leave it behind." Whether she will be able to put this into practice remains to be seen.

Chan will have to face many internal controversies at WHO—for example, whether the organisation should focus on setting policy or continue its in-country operational work; how WHO works with other UN agencies to avoid duplication and how it partners with newer, powerful players on the world public health scene, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Gates Foundation; whether its emphasis should be on communicable disease or perhaps on chronic illnesses that get less attention, such as diabetes and heart disease.

In her acceptance speech, Chan spoke with surprising directness on some of these issues, saying that "WHO is not the implementing agency within countries, but can support country priority setting." She also said that the organisation "must not spread our resources too thin… We must know our comparative advantage and stick with activities that WHO is uniquely well suited to perform." She did not, however, specify what those activities are.

She delineated two areas of especial concern to her: Africa and women. The section of her speech on women seemed to stem from genuine conviction. This is logical given that her early work was in maternal and child health. She made the point that when she spoke about women, she was not talking about maternal health alone. "Women do much more than have babies," she said, adding, "Unfortunately their activities in households and communities, coupled with their low status, make them especially vulnerable to health problems—from indoor air pollution and multiple infectious diseases to violence."

In November, just before the WHO election, China hosted a trade conference for 48 African states in Beijing that resulted in $1.9bn (£1bn, €1.4bn) in trade agreements. In the portion of her speech where Chan stated that "the people of Africa carry an enormous and disproportionate burden of ill health and premature death," some might hear echoes of this recent wooing of Africa.

But Jerry Norris, director of the Center for Science in Public Policy at the Hudson Institute in Washington, DC, thinks that interesting developments may come from the burgeoning alliance between Africa and China: "Donors have had an amazingly patronising attitude, while China is more respectful. After 40 years of the same colonial paradigm, China takes a different perspective—it's a real partnership."

Chan's next move will be to select a deputy, a point the WHO Executive Board insisted on, after the sudden death last May of her predecessor, Lee Jong-wook of South Korea. In the past, some WHO directors general chose to have deputies, but others, fearing competition, did not.

Dr Lee had selected a deputy by writing the name of his chosen successor in a sealed letter. He discussed it with very few people at WHO. When Dr Lee died there was debate over the process and the validity of the letter. Hoping to avoid a repeat of this situation, the board stipulated that Chan must choose a deputy. Certainly, issues of geopolitical balance and the recompense of favours will play a role in this selection. Until Chan takes office in January, the acting director general, Anders Nordström of Sweden, will stay at the helm of the organisation. Chan will serve until June 2012. □

Anne Glusker *Geneva*

Additional reporting by Jane Parry, *Hong Kong*.