# NEWS

## Supreme Court decides on abortion

In a decision that seemed to settle nothing in the debate on abortion the US Supreme Court voted by five to four to uphold the "essential holding" of the 1973 Roe *v* Wade case, which allows a woman to have an abortion before the fetus becomes viable. Once the fetus is viable, states may restrict access to abortion if the pregnancy is not interfering with the mother's health. The decision means that the absolute bans on abortion in Utah and Louisiana are unlawful. Michael McConnell of the University of Chicago Law School faculty accused the court of "pouring gasoline on the controversy."

The decision, however, let stand four out of five contested parts of a Pennsylvanian law that restricts abortion. The new guiding principle in allowing such state restrictions is whether they pose an "undue burden," which was defined as a "substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."

Under the Pennsylvanian restrictions a woman must delay having an abortion for 24 hours after being given information by a physician on fetal development and the risks of abortion and childbirth; women under 18 must obtain the consent of one parent or a judge; and facilities providing abortions must make statistical reports to the state. The Pennsylvanian restriction that was struck down was that a married woman had to notify her husband before having an abortion.

Because many of these regulations have not yet been applied groups in other states may return to court to try to show that some of the restrictions do pose an undue burden. The 24 hour waiting period, for example, will pose difficulties for poor women who must travel long distances to an abortion clinic and cannot afford to stay somewhere overnight. Teenagers may try illegal abortion rather than tell a parent or face the confusing ordeal of going to court to get a judge's permission for an abortion.

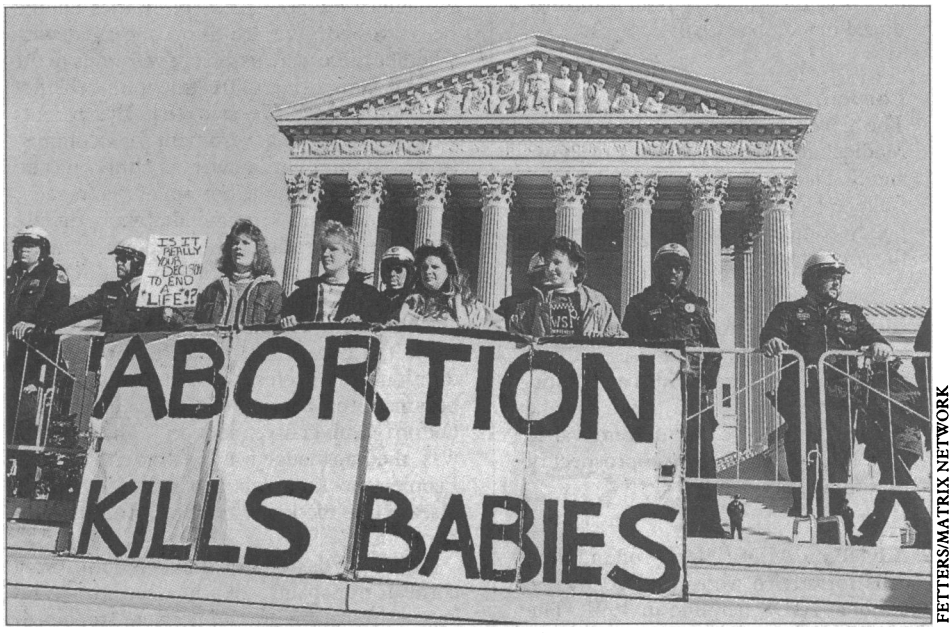
The proabortion and antiabortion forces waiting outside the Supreme Court immediately swung into action after the decision was announced, variously proclaiming victory and defeat. The three presidential candidates also gave their reactions: President Bush praised the decision for upholding "family values"; Democratic contender Bill Clinton said that he was committed to preserving the right to choose abortion, which he characterised as hanging by a thread; and undeclared presidential contender Ross Perot said, "This difficult decision should be a woman's choice."

For now, the unsettled abortion battle will switch to two other venues: Congress and various state legislatures. In Congress the Freedom of Choice Act, which would legally bar states from imposing restrictions on abortion before fetal viability, is working its way through the House, and the Senate will vote on it this summer.

President Bush is sure, however, to veto it, and pro-choice legislators do not believe they have the two thirds majority needed to overturn a veto. In the states where there is a patchwork quilt of regulations, legislative activity may not begin in earnest until January 1993 when the newly elected legislators take their place.

As the highly political and polarised fight on abortion continues many Americans are in the middle. Various polls, both recent and over the past 15 years, indicate that 54-60% of Americans believe that abortion should be legal under some circumstances. About 30% think that it should be legal under all circumstances and 10% believe that it should be illegal, according to polls conducted by the national opinion research centre at the University of Chicago.

As the Supreme Court made its decision by such a slim majority and the architect of the Roe *v* Wade decision—Judge Harry S Blackmun—is in his 80s and not likely to continue in office for much longer, there are likely to be more opportunities to rule on abortion within the next few years.—GAIL McBRIDE, medical journalist, Chicago




FETTERS/MATRIX NETWORK

*Abortion: demonstrations are likely to continue*

## Families of victims of Creutzfeldt-Jakob disease to sue government

Parents of young people who died of Creutzfeldt-Jakob disease after being treated with human growth hormone during childhood are to sue the British government for compensation. Seven young adults aged between 20 and 34 have died of the disease. Victims suffer from a rapidly progressing dementia.

The hormone came from the pituitary glands of cadavers that were processed at a Cambridge University laboratory under the aegis of the Medical Research Council until 1977 and subsequently at the government laboratory at Porton Down in Wiltshire. Most of the deaths have occurred in the past two years.

The government has rejected calls for a fund to compensate the families of victims and the 1900 young people treated with human growth hormone between 1959 and 1985. Use of the hormone was stopped after the first death was reported, and it was replaced by genetically engineered growth hormone. Worldwide figures put the current risk of developing Creutzfeldt-Jakob disease at 1 in 200, but as the incubation period could be as long as 35 years the eventual toll is unknown.

## Headlines

**Dentists vote not to accept new NHS patients:** Members of the British Dental Association and the General Dental Practitioners Association voted not to accept new NHS patients because of the government's introduction of a 7% "clawback" in dentists' fees. The cut in fees follows the recommendations of an independent review body brought in to look at dentists' fees after their new contract was introduced in October 1990.

**London medical schools merge:** The governing bodies of the United Medical and Dental Schools of Guy's and St Thomas's Hospitals and King's College have agreed to unite. A joint policy committee will be in charge of the procedure.

**Insuring for tattoo removal:** A bill was presented in the House of Commons by Mrs Teresa Gorman requiring people who have a tattoo to take out insurance to cover its removal to save NHS costs. It has no prospect of becoming law.

**Advice on AIDS:** Nearly one million calls for advice were received by the national AIDS helpline in 1991. The helpline costs about £1·8m a year to run and is funded by the Department of Health, other UK health departments, and health education agencies.

**Church and conservatives in Germany denounce abortion decision:** The Catholic church and conservative politicians have vowed to reverse the German parliament's decision last week to allow women to decide for themselves whether to have an abortion in the first 12 weeks of pregnancy.

**US fluoride overdose:** At least 260 people became ill and one man died when fluoride was accidentally released into drinking water in an Alaskan town; as a result over 40 times the safe dose was delivered. The state health department said last week that the accident had happened at the end of May.

**Poor immunisation uptake in New Zealand:** The Communicable Disease Centre's first survey on immunisation in New Zealand has shown that only 52% of 2 year olds are up to date with their immunisations. The most common reason given by parents for their child not being immunised was that the child had a cold.

More than half of the young people who received the hormone have yet to be notified that they are at risk. Unlike the US government, which immediately informed parents and patients after the first death, the British government kept the details secret for fear of causing panic. Only last year, after the sixth death, did the Department of Health agree to a programme to trace, notify, and counsel all recipients of human growth hormone. More than 90% have now been traced, but under half have been notified.

David Body, one of four solicitors handling cases, said: "It appears that before 1981 there may only have been the most general guidelines on how these pituitaries should be harvested. We are also concerned with whether there were sufficient warnings to the parents consenting to treatment on behalf of their children." He said that the parents were pressing the government for a commission of inquiry with powers of subpoena and discovery to get to the bottom of the tragedy.

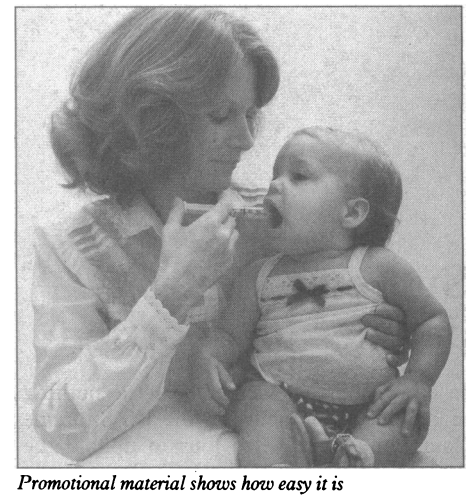
Evidence that Creutzfeldt-Jakob disease could be transmitted experimentally dates back to an article in *Science* in 1968. One of the authors, Bryan Matthews, then working at Derby Royal Infirmary, said: "Nobody made the connection. Somehow the penny didn't drop." Professor Matthews, who later became professor of clinical neurology at Oxford University, added: "The trouble was, the knowledge was in two departments. People who knew about Creutzfeldt-Jakob disease like me knew nothing about growth hormone."

In the 1970s cases of transmission from a corneal transplant, depth electrodes, and neurosurgical instruments were reported. One neurologist said that he suspected that these cases of "brain to brain" transmission were not considered relevant to the risk of transmission of purified extract by injection in another part of the body.—CLARE DYER, legal correspondent, *BMJ*

# Oral syringe replaces diluted medicines

Prescribed liquid medicines for small children are now to be given undiluted by oral syringe. The old practice of diluting medicines—in particular antibiotics—so that they could be given by a 5 ml spoon was abandoned on 1 July. The Department of Health has produced an explanatory leaflet for parents and provided posters for doctors' surgeries and community chemists.

"The syringes have been in use in hospitals for a couple of years already and seem to work well," said Roger Odd, head of the practice division of the Royal Pharmaceutical Society. "Medicines used to be diluted with syrup or water, and children were getting more volume than they needed. The medicines also did not last as long. The syringes will be used for only a small number of medicines and mostly in children, where the required dose is often 2·5 ml. It's important that pharmacists, doctors, and community nurses give advice to parents on how much they should give and how they should give it. It's important not to point the syringe at the back of the throat but to introduce the syringe into the side of the mouth."—LUISA DILLNER, *BMJ*



BAXA

*Promotional material shows how easy it is*

# Law catches up with dangerous driving

"Dangerous drivers: the law is catching up" is the slogan of a campaign to make people aware of new legislation on road safety. Introduced on 1 July under the Road Traffic Act 1991, new and revised measures will make it easier to prosecute and convict bad drivers and give stiffer penalties.

Dangerous driving and causing death by dangerous driving replace the old offences of reckless driving and causing death by reckless driving, emphasising the standard of driving rather than the state of mind. There is a new offence of causing death by careless driving while under the influence of drink or drugs, which will carry a maximum prison sentence of five years or an unlimited fine, or both, plus disqualification for at least two years. Under the old law an offender could be given no more than six months in prison. An extended driving test is now compulsory for people convicted of dangerous driving before they regain their licence, and an ordinary or extended test is discretionary for other driving offenders.

Automatic cameras will detect speeding offences and cars that jump red lights, the results being valid evidence in court (but only three police forces so far have the equipment).

Driving after making a false declaration about physical fitness; driving after failing to notify the onset or deterioration of a disabling condition; and driving after a licence has been refused or revoked on medical grounds are new offences, which carry fines, penalty points, discretionary disqualification, and (in the last case) possible imprisonment.

From October exceeding speed limits will carry increased fines and, as at present, discretionary disqualification—for example, the maximum fine for exceeding the speed limit on motorways will increase from £1000 to £2500. Increased penalty points could lead to disqualification after only two offences.—DAPHNE GLOAG, *BMJ*

# Sterilisations up in eastern Germany

If a woman in the former German Democratic Republic (GDR) wanted to be sterilised the psychological and bureaucratic hurdles were high. First she had to seek the written opinion of a gynaecologist on the medical necessity of the intervention. Then a public district commission had to discuss the social and economic aspects of the case and make a decision. Only about 200-400 women a year got through the procedure. Many others, as Dr Thomaa Knaus of Leipzig University Hospital, says, "shied away from it."

This situation, however, has drastically changed in the two years since Germany was reunited. In the Women's Hospital of the city of Magdeburg alone the number of sterilisations in women has risen from just eight in 1989 to 1200 in 1991. In Berlin last year about 7000 sterilisations were performed, most of them on women from former East Berlin.

There are various reasons for the development. Firstly, there is a backlog in demand from women from the former GDR who did not want to go through the procedure of getting permission. Another reason is that newly wed couples in the former GDR were granted interest free parenthood loans of up to 5000 marks, which were never fully called in if the couple had children. After these allowances were stopped in 1990 the birth rate in eastern Germany fell considerably.

The third reason for the rise in sterilisations is more questionable: as unemployment in eastern Germany is still rising women are now undergoing sterilisation to improve their chances of finding a job. According to German labour laws, employers are not allowed to ask women applicants whether they are pregnant or plan to have more children. There is evidence, however, that personnel managers are encouraging women to produce hospital certificates proving that they have been sterilised.

Editha Beier, commissioner for women's equal rights in Magdeburg, reported the issue to *Der Spiegel*. She claimed that in some cases personnel managers had urged women applying for jobs to undergo sterilisation: "Do it, and the matter is fixed up."

Professor Dr Wolfgang Weise, director of the Women's Hospital in Magdeburg, who is known for objecting to liberal abortion laws, even sees something good in it: "Every sterilisation is better than an abortion."—HELMUT L KARCHER, science writer, Munich

# Bangkok's epidemic of lead poisoning

Bangkok's growing population of urban poor, particularly the young children of families with low incomes, face irreversible damage to their health because of pollution from the city's traffic. Doctors from the Public Health Ministry in Thailand studying 210 schoolchildren have found evidence of neurological damage linked to poisoning with heavy metals. The children, all attending an elementary school run by the government that is situated next to a main road, were tested for exposure to lead. Thirty per cent were found to have oral lead lines—deposits of lead sulphide traced across the upper and lower gums—which indicate significant heavy metal poisoning. Many of these children, aged 8 and 9, failed tests of balance and manual dexterity. Urine tests were done, and the overall results of the study are now being analysed in detail.

The Thai capital is also cited in a recent report by the World Bank as a city where airborne lead concentrations, primarily from vehicle emissions, are causing serious health problems. "Estimates for Bangkok suggest that the average child has lost four or more IQ points by the age of 7 because of elevated exposure to lead," states the *1992 World Development Report*. "In adults the consequences include risks of higher blood pressure and higher risk of heart attacks, strokes and death."

Another study, conducted in 1990, found that the blood lead concentrations of newborn babies were higher than those found in the early 1980s. Charles Setchell, a US Fulbright research scholar studying urban development issues in Bangkok, said, "The increase was found to be directly attributable to exposure of the mother to Bangkok's polluted air during pregnancy. Bangkok's young children now have among the highest blood lead levels in the world, even exceeding the levels found among the children of Mexico City, long thought to be the city with the worst air pollution in the world."

The Thai government, continually criticised for failing to address Bangkok's traffic congestion and pollution crisis, introduced unleaded petrol in May 1991. Legislation has been introduced that will require all new petrol engine cars to be equipped with catalytic converters, which reduce emissions of soot and acid gases, by September 1993. Much of Bangkok's traffic pollution, however, is generated by older, poorly maintained public service vehicles—buses and taxis—which have diesel engines and cannot use unleaded petrol.

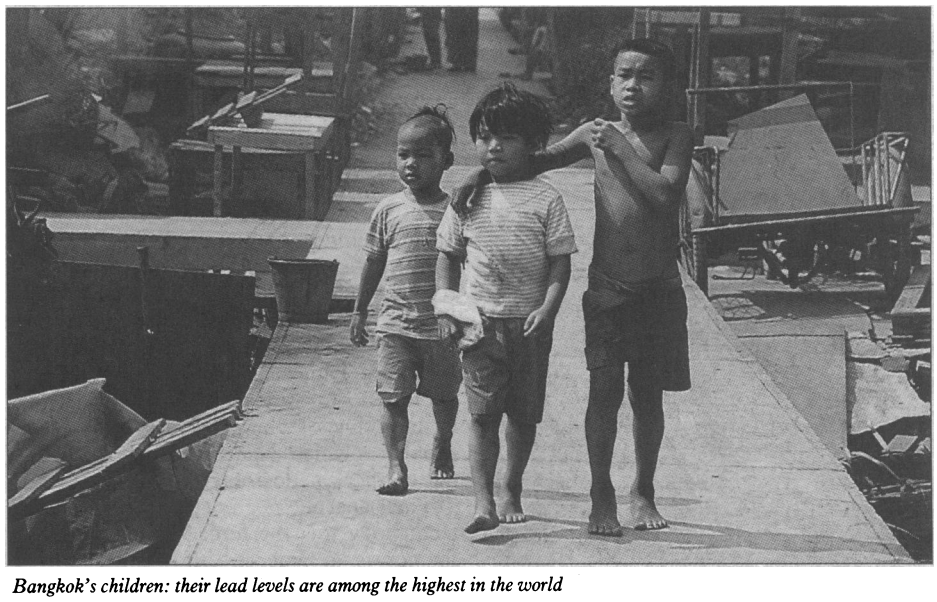
Hundreds of thousands of poor families living in Bangkok's 1500 slum settlements will be exposed to even worse conditions as the number of vehicles on the capital's streets increases. A report in 1990 estimated that 900 000 people in Bangkok—a city of nearly eight million—suffered from chronic respiratory problems related to air pollution.—ALISON CLEMENTS, freelance journalist, Bangkok

# Birth of student edition of *BMJ*

From October student members of the BMA will have their own monthly journal. The new journal will also be marketed to students outside Britain. The 48 page *Student BMJ* will have one third of its pages specially commissioned for medical students while the remaining two thirds will consist of relevant articles selected from the *BMJ*.

The new journal aims not only to help students pass exams but to encourage them to read scientific papers and think critically about medical information. Some of the articles will be practical—how to put up a drip or apply for house jobs. Others will deal with the ethical issues in medicine and the stresses that students may encounter either emotionally or financially. Some of the articles will be written by students themselves and certainly many of the ideas will come from them. The editor in chief will be the *BMJ* editor, and the editor will be Luisa Dillner, who was a surgeon in training before she joined the *BMJ*. She would welcome suggestions for articles.

A monthly student journal was the centrepiece of a package drawn up by the BMA's recruitment strategy working group after the annual meeting endorsed a request from the medical students group committee that the association should actively recruit preclinical students and offer them targeted membership benefits.



SEAN SPRAGUE/PANOS

*Bangkok's children: their lead levels are among the highest in the world*

Before a decision was taken medical students and deans were asked for their opinion. Both groups favoured a student journal, although they thought that it was important for students to be able to opt to receive the weekly *BMJ* in their final year. This option will be provided. Current student members already receiving the *BMJ* will also be given the option to continue to receive the weekly *BMJ* for the remainder of their course.

The chairman of the students' committee, Jo Andrews, believes that students will welcome a journal tailored for them.—LINDA BEECHAM, *BMJ*

# 16 year old's refusal of treatment overruled

A 16 year old girl suffering from anorexia nervosa can be treated against her will, the Court of Appeal ruled last week in the first case in Britain to test the rights of 16 to 18 year olds to refuse medical treatment. The decision was given without reasons at the end of a day and a half of legal argument so that the girl, J, who had taken no food for nine days, could start treatment immediately. As we went to press lawyers were awaiting the full judgment with reasons, which was expected late this week.

The ruling upholds a High Court decision that the court, in its inherent jurisdiction over minors, can override the refusal of a legally competent 16 to 18 year old to undergo treatment. The case is almost certain to go to the House of Lords and become, with the Gillick case—which concerns the rights of under 16s to take decisions regarding treatment—a leading authority on children's rights to self determination in medical treatment.

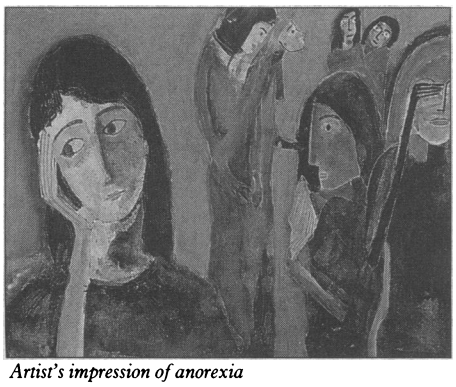
Meanwhile, J last week began a three month programme of treatment at a unit for eating disorders in a London hospital. Her counsel, Allan Levy QC, told the court that she was unhappy about its decision but had "bowed to the inevitable" and was willing to cooperate. Lord Donaldson, master of the rolls, and Lords Justices Balcombe and Nolan made the ruling after hearing that J would start to suffer permanent damage to her brain and reproductive system if she continued to fast for a further week. Lord Donaldson said that the girl's views carried "no weight" in the decision on whether she should be treated, although they should be taken into account in the choice between alternative regimens.

The judgment in J's case should clarify an area of the law that was thrown into confusion last year when the Appeal Court, again headed by Lord Donaldson, ordered that an emotionally disturbed 15 year old girl, R, be given antipsychotic drugs against her will. The case differed from J's because the court decided that R, although she had lucid intervals, was not capable of taking her own decisions. In addition, J, a year older, was able to invoke section 8 of the Family Law Reform Act 1969, which gives 16 to 18 year olds a statutory right to consent to medical treatment (which, her lawyers argued, must include the right to refuse). Under 16s who are mature enough to understand the treatment proposed have the same right under common law, the House of Lords decided in the Gillick case.

The confusion was caused by remarks made by Lord Donaldson in R's case. He said that while a teenager under 18 could consent to treatment, so could a parent (this would include a local authority if the child was in care). If the child refused doctors could go ahead on the basis of the parent's consent.

This interpretation of the law, which runs counter to the philosophy of the recent Children Act and accepted views of the meaning of the Gillick case and section 8 of the Family Law Reform Act, was widely criticised by academic and practising lawyers as wrong and perverse. Neither of Lord Donaldson's two fellow appeal judges in the R case adopted it, but the High Court judge who ruled in May that J could be treated against her will cited it with approval, and lawyers were anxious last week to see what the Appeal Court would say on the subject when it delivered its judgment in J's case.

J's solicitor, Major Somerton, said that she was "understandably depressed" about the ruling. J, who was orphaned before the age of 10 when both parents died of cancer, had unhappy experiences in foster care and started losing weight after the death of her much loved grandfather two years ago.—CLARE DYER, legal correspondent, *BMJ*



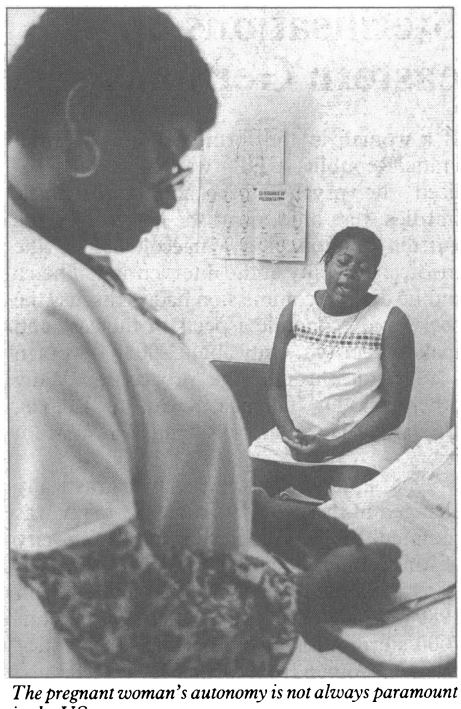
LOUISE WILLIAMS/SCIENCE PHOTOS

*Artist's impression of anorexia*

# Forcing treatment on pregnant women

What should obstetricians do when a pregnant woman refuses the treatment that they recommend? Should they get a court order forcing her to undergo treatment for the wellbeing of her fetus? Last month the March of Dimes, an American foundation dedicated to preventing birth defects, brought together a panel to examine this problem, which is confronting more and more American doctors.

The panel members agreed that medical technology was the force behind the trend for courts to order treatment. Mr Lori B Andrews, a research fellow of the American Bar Foundation and a senior scholar at the University of Chicago Center for Medical Ethics, said, "Ultrasound gives a real time picture of the fetus. Doctors want to protect the new individual."



VAL WILMER/FORMAT

*The pregnant woman's autonomy is not always paramount in the US*

The antiabortion movement in the US, which views the fetus as an unborn human being with certain rights, similarly supports the view of the fetus as an individual. This view has intensified as techniques to treat the fetus in utero have become available. Six states now have statutes, similar to those for child abuse, which make the reporting of fetal abuse mandatory.

When a pregnant woman refuses treatment the legal principles involved are beneficence—the obligation of doctors to promote the wellbeing of both woman and fetus—and autonomy—the right of the woman to choose or refuse the recommended treatment. The moral conflict is increased when the procedure may harm the mother. This may happen in an intrauterine correction of a congenital defect or a caesarean section. The conflict is now extending to controlling a pregnant woman's smoking or drug taking if it threatens the wellbeing of the fetus.

What is disturbing about this trend is that, as Mr Andrews said, "In 81% of the cases that have gone to court the patient was a minority woman with a white male physician." Women are usually charged under laws governing child abuse or for delivering drugs to a minor.

So far 166 cases have gone to trial in 26 states. Just over half the women were sentenced to jail, and 11% received a court order to undergo treatment. Yet in cases in which women were beaten by their partners and miscarried no action was taken against the man.

Another member of the panel, Richard Schwarz, an obstetrician at the State University of New York Health Science Center at Brooklyn, said, "Professional liability is a major concern. People expect perfect babies."

In several states district attorneys who

prosecute pregnant women for drug misuse may want to be seen to be doing something that helps the next generation and combats drug misuse. "It's counterproductive," said Dr Schwarz. "Criminal charges will drive women away from seeking care." In South Carolina, where pregnant cocaine users must have treatment or face prosecution, Mr Andrews said, "an increasing number of women are delivering in taxis and bathrooms. There already seems to be a trend of avoiding care."

Dr Schwarz, who works at a public hospital, said, "As an obstetrician I feel that the judicial solution should almost never be used. The idea of taking a pregnant woman who really refuses a procedure, tying her down, and anaesthetising her is repugnant. In many of these situations the science isn't hard enough to say that the results of the woman's decision to avoid treatment would be bad."

The American College of Obstetricians and Gynecologists and the committee on bioethics of the American Academy of Pediatricians support the view that the pregnant woman's autonomy is paramount and that asking a court to intervene should be a last resort in rare cases.—JANICE HOPKINS TANNE, contributing editor, *New York*

# Human Fertilisation and Embryology Act may loosen up

A bill going through parliament should ease the restrictions placed on the release of information about patients receiving treatment for infertility by the Human Fertilisation and Embryology Act 1990. The circumstances in which disclosure will be permitted will be closely defined, but the bill will remove the criminal sanction from disclosure in specified circumstances and for particular purposes. The patient's consent will be required before any identifying information can be disclosed, but information can be disclosed if the patient's health is in danger or it is not practicable or possible to obtain consent.

Since the act came into force there has been evidence that the restrictions were too tightly drawn, leading to unintended risks and difficulties. The act prohibits fertility specialists from writing to referring consultants or general practitioners about their patients or from communicating any details of patients' treatment by telephone.

The restriction could result in a woman developing a serious complication of treatment, which could go unrecognised because her general practitioner or another doctor had not been given details about her infertility treatment. In a letter to the *BMJ* Dr Peter Brinsden of the Bourn Hall Clinic, Cambridge, wrote: "We have protested vehemently that this is an unworkable and dangerous regulation and is utterly opposed to our profession's normally accepted belief in good communication between colleagues" (*BMJ* 1991;**303**:309). Last month's local medical conference strongly objected to the "situation created by act of parliament whereby in vitro fertilisation centres are prohibited from communicating with general practitioners."

Another example of the overrestrictive nature of the act is that it prevents disclosure of information for legal purposes. If doctors at an infertility centre were sued by a patient they would be unable to give their legal adviser information about the treatment given to a patient. The patient would not be subject to such restraints by the act. The Human Fertilisation and Embryology (Disclosure of Information) Bill had its third reading in the House of Lords last week; as it has government support it is likely to become law.

• In its annual report for 1992 the Human Fertilisation Embryology Authority agrees that the extent of the restrictions in the act has consequences that were unforeseen and are potentially dangerous.

Its report states that 2004 pregnancies were achieved last year in 64 centres, resulting in 1443 births. The authority said that women aged 25 to 29 were most likely to get pregnant. Only six women in 100 over 40 had a baby, and no babies were born to women over 45 who had been treated.

Apart from the code of practice, which is in use in all centres offering treatment, storage, and research facilities, information services for collating treatment and research data and information that could be given to a child born as a result of treatment have been implemented. In addition, by 1 August a monitoring system will be in place for all the centres licensed with the authority.—LINDA BEECHAM, *BMJ*

# Cardiac catheterisation takes to the road

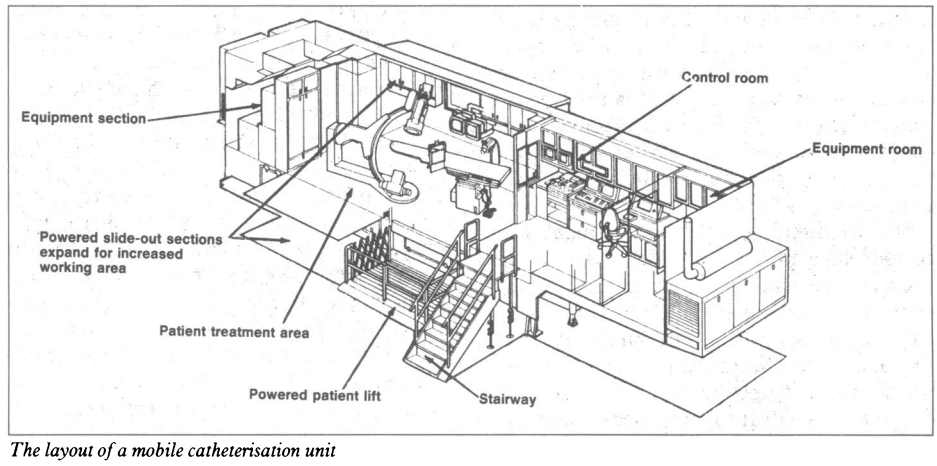
The large trailer that was set down in a car park behind the conference centre in Harrogate at the British Cardiac Society's annual meeting is the first mobile catheterisation laboratory in Europe. The fully digital suite is the latest example of what could become a trend in high tech contracting out if Britain continues to follow America's lead. Britain already has six mobile magnetic resonance imaging (MRI) units (the first one arrived in 1989), two computed tomography (CT) units, and two lithotripsy units.

In the early to mid-1980s a couple of entrepreneurs in the United States realised that many hospitals were keen to meet a growing demand but reluctant to buy expensive CT scanning facilities that would not be used every day. They thought, "Why not put it on a truck and move it around?"—a much more cost effective approach that did not require capital investment by the hospitals.

Manufacturers, who recognised the viability of mobilising their equipment, developed products designed to be transported in customised vehicles with specialised suspension and shielding against magnetic fields, radiation, and radiofrequency waves. The equipped vehicles are bought by service providers, who hire them out per day or per unit procedure.

The fee for the British mobile catheterisation laboratory includes the services of a radiographer, nurse, and cardiac technician. One service provider has paid about £800 000 for the first unit and is set to order a second one in October. The plan is to serve both private and NHS hospitals, not only as an emergency back up but to reduce waiting lists where a cardiologist normally has to share facilities and to go to district hospitals in the catchment areas of regional cardiothoracic centres to save patients travelling.

Some cardiologists, however, have reservations about the use of the mobile units in district hospitals. Dr Peter Mills, a consultant cardiologist at the Royal London Hospital, said, "There are risks in cardiac catheterisation that don't obtain with CT or MRI scanning. Providing a back up unit at an established cardiac unit when it is closed for servicing or for major development would seem to be an effective use of mobile units. However, the safety of performing cardiac catheterisation without cardiac surgical facilities on the same geographical site is a question that will be brought into sharper focus by the existence of mobile units. As a cardiologist in an established centre, I would consider using a mobile unit if it was cost effective."—JANE DAWSON, *British Heart Journal*




CALUMET COACH COMPANY

*The layout of a mobile catheterisation unit*

# Grand design

Untroubled by parliamentary opposition, Britain's health ministers have had the stage to themselves for three months, so that since the election the dominant voice on health policy has been the government's. Driven by a fresh mandate, the government is aiming to consolidate and expand the NHS reforms in all directions.

The reform juggernaut is already propelling three quarters of health services in England and half of those in Wales to self governing trust status by next year. The health secretary, Virginia Bottomley, did not even trouble to mention these when she addressed health authorities at the end of last month, yet I still counted 15 references in her speech which could be termed as future developments. When this speech is coupled with a similar keynote speech to managers two weeks earlier it becomes clear that Mrs Bottomley will be miles down Reform Road before parliament's sleeping watchdogs catch up.

The secretary of state identifies her three priorities for this year as community care, the patient's charter, and the white paper *Health of the Nation*, which was ready for publication this week. But she goes on to mention other items on her agenda that would seem to be equally important. I select two at random: the review of health services in London this autumn and a continuing appraisal of what she calls "the whole future method and style of management of the modern NHS." Add to these such projects as the establishment of two new centres to collect and analyse data on health outcomes, plans to expand NHS research, and the setting of regional productivity targets and the list begins to defy comprehension.

Two other initiatives concerning general practice may be relatively minor pieces in Mrs Bottomley's grand design but may be of more direct interest to doctors and their patients. One is the proposal to extend the patient's charter into primary health care. The other is a pilot scheme to spread general practice fundholding to singlehanded practices. Both are intended to grow from the bottom up, which means adjusting them to suit local circumstances.

The general practice version of the patient's charter will set out guidelines about patients' rights of access, the availability of doctors to their patients, and a two way exchange on how to improve services. Within the Department of Health a task force has begun work to implement the patient's charter and ensure that its do's and don'ts are built into NHS contracts.

On fundholding, the department has decided how to flesh out the pledge in the Conservative manifesto to make fundholding available to any general practitioner who wants it, irrespective of minimum list size. Six pilot sites, containing 30 inner city practices and 46 doctors, have been selected. The practices will group together to purchase health care and will be able to delegate the administrative work to an agency funded by the health authority. This form of help will be equivalent to the start up aid and computer grants given to fundholders in the larger practices. Most of these pilot schemes will be up and running this year.

One watchdog that does not sleep is the health service commissioner, or ombudsman, whose office has been described as the grumbling appendix of the NHS. His annual report last week registered a 19% rise in complaints, to a total of 1176, which he attributes to growing public awareness of his existence. An interesting sequel this year is that Mrs Bottomley invited the commissioner, Mr William Reid, to meet her to discuss how the NHS can reverse the trend. This chimes in with another of her themes: an emphasis on improving the quality of service.

Both the secretary of state and the ombudsman concur that better quality stems from action not words. As his report states: "Improvements in service result from what staff do rather than from slogans or procedures, however well they have been drafted." That in the end is the real message.—JOHN WARDEN, parliamentary correspondent, *BMJ*

## *The Week*

### Dithering doctors?

"As doctors dither" was the headline in the *Times* that greeted BMA representatives as they started their annual meeting in Nottingham—and might have served as a subtitle to the first couple of hours. The problem, as both the *Times* and later David Bolt, a past president of the BMA, pointed out, is that doctors themselves are divided about the reforms. When the leadership gets as many brickbats from doctors who want to embrace the reforms as they do from those who want to oppose them, then leading them is not easy.

And leadership was once again at issue. Would Jeremy Lee Potter successfully pull the divided ranks of the profession behind him? Or would this year's ARM, like last year's, be marred by lack of confidence in his style? Given his opening speech to the conference and subsequent motions, the answer is probably "yes"—to both questions. The position that the chairman of council spelt out in his speech is not new, but he declared it with clarity and a new confidence. The four principles that he spelt out put patients first, accepted that the reforms were here to stay, reasserted that doctors were professionals, and argued that they should therefore work constructively in the interests of patients to make sure the NHS worked properly. He was, he said, tired of petty bickering being the dominant public perception of medicine today.

Nearly everyone in the hall would have agreed with that sentiment—but ARM agendas have a momentum all of their own, and the debates on the first two substantial motions of the morning immediately undermined the chairman's plea to bury the past and get on with addressing current problems. Jeremy Lee Potter got a warm (though not rapturous) reception for his speech, but almost as soon as he had sat down the bickering began again. First, the meeting narrowly passed a motion (after a count) regretting that BMA policy on the health service reforms was not being pursued as vigorously and imaginatively as the generality of the membership would wish. The next motion—passed on a show of hands—expressed confidence in the chairman of council in his approach to responding to legislation. In explaining the problems of a divided profession David Bolt pointed out that there was no more difficult position for a leader than to know that the people he is leading are violently divided. That position is made no easier when one of his sternest critics is a previous chairman of council: in criticising the leadership's lack of vigour in pursuing BMA policy, however, John Marks said he was voicing the sincerely held opinion of many members. Others welcomed the (current) chairman of council's statesmanlike approach and claimed that the people they represented wanted, like him, an end to petty politicking.

The difficulty is that repositioning policy in a climate of radical change is difficult. Perhaps Dick Greenwood, council's iconoclast and bogeyman, had the best image: "When the Titanic hit its iceberg," he said, "at least it was going somewhere." He wanted all the chief officers and all the council (including himself) to be sacked: they were grey men and women with grey ideas. Let the crafts run their own affairs since they did it extraordinarily well. On that score he is right; by and large the crafts do run their affairs well: most of the progress that has been achieved in easing the effect of the reforms has been done at craft level. But the perception of competence that attaches to the crafts has not managed to extend to the BMA as a whole; the impression that remains is of disagreement and disarray. That's a danger for the BMA—and the profession—that wasn't helped by the first morning's debates.

HART