The drug laws: ripe for reform?

Release, the national drug and legal advice agency, has called for a "bold but controlled" change in the laws banning the use of illicit drugs. Decriminalising drug use would, it says, free money currently wasted on ineffective policing, allow the introduction of measures to curb the spread of AIDS, halt the crime wave caused by drug users' need for massive income, and prevent the corruption and violence associated with huge illicit profits made by the drug barons.

Release has published a consultation paper, which marks its 25th anniversary and the coming of age of the Misuse of Drugs Act—21 this year. Enforcement of the drug laws is totally ineffective, it argues. Prison is not a deterrent to users, who simply carry on the practice inside, sharing needles and spreading HIV. The necessity for "intrusive and distasteful policing" destroys any existing relationship between vulnerable communities and the police and invites the kind of riots that shocked the public in Brixton in London and St Pauls in Bristol, it warns.

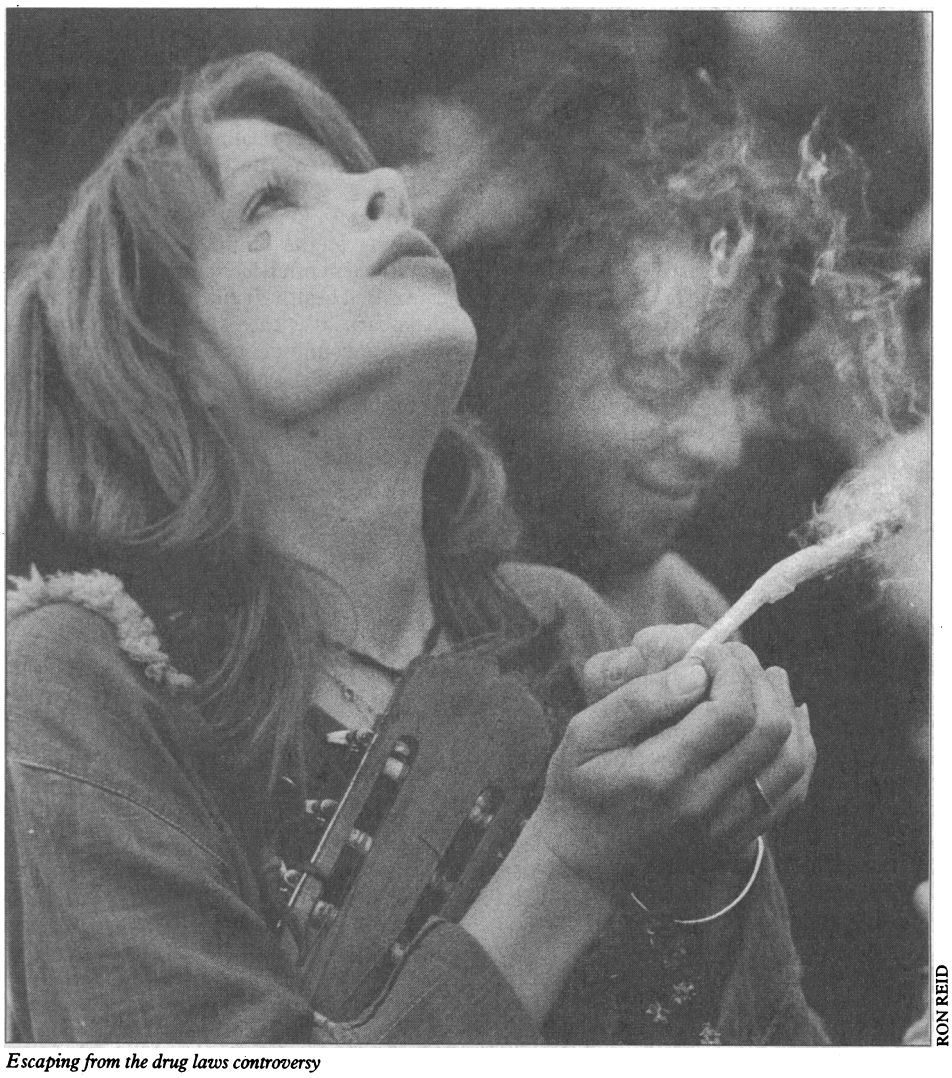
Release argues that prohibiting recreational drugs such as ecstasy and cannabis simply results in massive profits for dealers, who poison teenagers with counterfeit or impure drugs.

According to figures from the home office, a quarter of all youngsters break the law on drugs at least once. Drug offences and related crime are the most widespread form of serious crime in Britain. In 1990, 44 922 people had dealings with the police over drugs, nearly four times as many as in 1975 (11 846). This criminality is a massive drain on government resources, says the report, and the situation worsens every year.

Mike Goodwin, the director of Release, said, "Almost all of the tragic health problems we see stem from prohibition. Hepatitis, septicaemia, and multiple abcesses all result from unsafe needle practices that users are forced into. Deaths from overdoses are often caused by the variable amount of the active ingredient in street drugs because it can't be regulated."

The consultation paper outlines several possible options for changes in the law. All the proposals embrace the principle that drugs must be controlled and properly licensed and their content regulated. Possibilities include allowing the possession of small amounts of drugs for recreational use; legalising hard drugs but rationing their use to drug dependency clinics and regulated pharmacies; and allowing licensed premises where users can buy regulated drugs and use them in safe circumstances.

Said Mike Goodwin, "There are no perfect solutions to this problem; it's really a matter of simply trying to reduce harm. We know that, whatever the law, most people will never want to use hard drugs."—ALISON TONKS, *BMJ*



RON REID

Escaping from the drug laws controversy

A Release White Paper on Reform of the Drug Laws is available from Release Publications, 388 Old Street, London EC1V 9LT, price £3.50.

Unemployment and health in Sweden

Unemployment leads to increased psychosomatic and psychological symptoms, decreased social activity, increased drug and alcohol misuse, and increased use of health care services, according to Dr Anne Hammarström of the department of social medicine at the Karolinska Institute in Stockholm. She claims that unemployment, among young people, is one of the most serious problems of the Western World.

The problem is new in Sweden, where the rate of unemployment has been just over 1% for some time. But the rapid increase during the past couple of years—unemployment doubled between May last year and May this year—has shocked many Swedes, although economists had predicted the recession. Sweden has been living beyond its means, and now the effects are becoming obvious. Current unemployment figures show that 4·4% of the workforce is unemployed, and in young people aged 18 to 24 the figure is 8·9%. This is the highest on record since 1963.

Young men and women react differently to unemployment, Dr Hammarström told a recent seminar on unemployment and health run by the Nordic Council. Young women have more physical symptoms. She had interviewed one girl who developed a rash

Headlines

Athletes targeted for needle exchange: West Glamorgan Health Authority has begun a campaign to inform athletes of a needle exchange scheme aimed at sportsmen and sportswomen who inject anabolic steroids. The scheme has received a grant of £8000 from the Welsh committee on drug misuse.

Cases of salmonella poisoning increase: According to the Public Health Laboratory Service, the number of people suffering from salmonella food poisoning has increased by 82% since this time last year. There have been 11 832 cases so far this year.

Australian worker compensated for melanoma: An Australian bricklayer who died from a melanoma on his scalp after working 17 years in direct sunlight has been awarded $A100 000 by Victoria's compensation tribunal. The bricklayer worked for municipal authorities, who now fear a flood of similar lawsuits.

American act bans discrimination against physical disability: The Americans with Disabilities Act came into force this week, making it illegal for employers to ask questions about physical disabilities on job application forms.

Baroness Cumberlege to chair maternity care committee: The expert committee asked to review government policy on intrapartum care will be chaired by Baroness Cumberlege. The expert committee was set up in response to the select committee's report on maternity services.

Fall in road deaths: Latest figures from the Department of Transport show a drop of 12% in deaths from road traffic accidents compared with 1990. Pedestrian casualties fell by 10% and casualties among cyclists fell by 6% over the same period.

Labour's health spokesman: Mr David Blunkett, MP for Sheffield Brightside, has been appointed shadow secretary of state for health in Mr John Smith's shadow cabinet.

British diet under scrutiny: The Ministry of Agriculture, Fisheries and Food, in conjunction with the Department of Health, has commissioned a series of surveys of British eating habits. The study, which looks at four different age groups, will provide information on intakes of over 50 nutrients.

each time she was out of work, which resolved as soon as she got a job. Girls also suffer more psychologically as they feel guilty and worry about being a burden to their families.

Young men do not claim to become physically ill as a result of unemployment but admit that they drink more, lapse into unhealthy behaviour, and get involved in crime. They do not feel guilty. Young men are, therefore, more likely to end up permanently unemployed. According to Dr Hammarström, men's reactions to unemployment are more obvious and therefore receive more attention. She says that the health care sector should be more alert to the effects of unemployment on women.

Professor Steinar Westin from Norway, speaking at the seminar, warned that unemployment often led to early retirement because of ill health. It enticed the unemployed to embark on a "career of illness," he said.

The only fully effective remedy is meaningful employment, but to provide that during recession is difficult. Last month the Swedish government began a vocational training scheme, which provides places for 40 000 unemployed 18 to 24 year olds for six months. Companies offering places to young people are to be reimbursed from the Labour Market Board's funds.—AGNETA MARIA LEWIS, freelance journalist, Stockholm

Loophole in tobacco code

The new voluntary agreement on advertising and sponsorship between the British government and the tobacco industry has run into difficulty in its first year of operation. Sir John Blelloch, chairman of the committee that monitors the working of the agreement, COMATAS, reveals in his annual report an unresolved issue between the government and the tobacco industry over the code on promotion of cigarettes. The question is whether free cigarettes can be advertised in free newspapers.

Under the agreement tobacco companies may use press advertisements to invite adult smokers to apply for a voucher which can be exchanged for cigarettes at a retail tobacconist. But the agreement bans delivery of "unaddressed or anonymously addressed" promotional offers. It is therefore arguable that promotional offers of free cigarettes contained in free newspapers and delivered through letterboxes unaddressed are ruled out. The distinction is between papers chosen by the reader and those that are supplied free whether or not they are wanted.

Sir John's report states: "I have not, I am afraid, been able to resolve these two positions within the committee as the voluntary agreement is not clear on this point. The working of the agreement would be improved if this issue were put beyond doubt."

When the committee is split the usual procedure is for the independent chairman to decide one way or another, but on this occasion he has chosen not to do so. Nor are there plans to alter the agreement before it is renegotiated, which cannot be before June 1994. In the meantime, six complaints about tobacco promotion remain unresolved.

Critics of the voluntary agreement will use this example to illustrate its impotence, especially as one purpose of the code on cigarette promotion is to reduce the likelihood of offers of free cigarettes falling into the hands of young people.

Tobacco advertising on shop fronts was the main cause for complaints in the past year, accounting for 54 out of 119 alleged breaches of the agreement. Thirty one of the breaches were upheld.

In a written parliamentary reply the secretary of state for health, Mrs Virginia Bottomley, said that the annual report shows that the tobacco industry "has continued to honour its commitments."—JOHN WARDEN, parliamentary correspondent, *BMJ*

SALLY AND RICHARD GREENHILL

Unsolicited mail

Treasury tightens its grip on public spending

The annual public expenditure round in Britain has this year seen a considerable shift of power towards the Treasury. The chancellor of the exchequer will have the first and last say over departmental budgets, of which the NHS's £36 billion is the second highest.

The Cabinet last week agreed that government spending in 1993-4—to be announced in November—would not rise above the planned total of £245 billion. This means cutting £15 billion from the bids already submitted by ministers. Under a new system the Treasury will divide the money as it sees fit. Ministers will now know their allocation before they begin negotiating with the chief secretary, who is in charge of public spending. If there is disagreement the final

arbitration will not, as before, be by a neutral "star chamber" but by a cabinet committee presided over by the chancellor.

Spending on health is not exempt from what is meant to be the toughest clamp on public expenditure for 10 years, though a mood of relative optimism prevails in the Department of Health. The optimism is based on the Conservative election manifesto's commitment, which Department of Health officials quote readily, though with a certain read-my-lips scepticism. It states: "We will, year by year, increase the level of real resources committed to the NHS." On the strength of that, planned spending on the NHS in England is projected to rise by £1·8 billion. But as that is 2·75% above inflation it still leaves scope for the Treasury to cut £500m without breaking the manifesto pledge.

The NHS Management Executive's new guidance to health authorities (below) is prudently laced with caution about budgetary controls. These include an exhortation to monitor general practitioners' remuneration "and investigate exceptional patterns of spending." The priority accorded to introducing comprehensive community care from next April will be the main new pressure on NHS resources.

The health secretary, Virginia Bottomley, recently summed up the prospects for health spending when she said: "I shall not return from the Treasury with enough cash to trigger the mass throwing of hats in the air. No secretary of state ever will. After all, the NHS has had three good settlements in a row and hats have remained resolutely on heads."—JOHN WARDEN, parliamentary correspondent, *BMJ*

ULRIKE PREUSS

Making the seamless web work: a priority for 1993

NHS priorities for 1993

The priorities for the NHS in 1993-4 are to implement *The Health of the Nation*, to ensure high quality health and social care in the community, and to develop the patient's charter. In issuing these priorities and planning guidance last week Duncan Nichol, NHS chief executive, said that 1993-4 would be the year in which the NHS developed the direction of the health service for the next decade.

The three priorities would, said Mr Nichol, "deliver improved health for the population and secure better health services for individuals." They are underpinned by two key objectives: to improve efficiency and value for money and to improve the effectiveness of "our organisation." The guidance explains what needs to be done under each objective, though it offers little help on implementation.

In practice, regions, districts, family health services authorities, provider units, and general practice fundholders will have to respond to a detailed set of demands. Under the overall objective of improving health, for example, the NHS will not only have to meet the targets set out in *Health of the Nation*; authorities also have to improve maternity and neonatal services, increase the numbers of hip and coronary artery bypass operations, improve services for mentally disordered offenders, and become healthy employers. Regions must spend more on research and development.

To provide better services the NHS is enjoined to pay particular attention to working with local authorities to make community care work and to enforce the patient's charter (including new standards for priority care groups and primary care, which will be issued in the autumn). They must also continue to reduce waiting times (aiming at a maximum of 18 months), expand day surgery, implement nurse prescribing, and integrate primary and secondary care.

Finally, the guidance urges continuing organisational change and staff development. Purchasers must develop their directly managed units to enable them to apply for trust status, and regions should encourage general practitioners who wish to become fundholders. Regions in particular are responsible for managing the market, determining the size of purchasers, improving equal opportunities, implementing the new deal on juniors' hours, ensuring consultant expansion by 2% a year, and ensuring that standards of teaching and research are maintained.—JANE SMITH, *BMJ*

AIDS without HIV

Researchers at the eighth international conference on AIDS in Amsterdam last week reported evidence of a disease similar to AIDS but without HIV infection. Amid media frenzy and midnight press conferences, they urged caution while promising immediate action.

"We must be careful and not panic while we aggressively pursue the facts," said Dr Anthony Fauci, director of the AIDS programme at the US National Institute of Allergy and Infectious Diseases. The World Health Organisation will hold a meeting soon on the new immunodeficiency, said Dr Michael Merson, director of WHO's global programme on AIDS. Dr James Curran of the US Centers for Disease Control (CDC) said that known cases would be reported in *Morbidity and Mortality Weekly Report*, and he called on American doctors to report new cases to the CDC.

Officials at the conference hastily called a special scientific session to discuss the findings of Dr Jeffrey Laurence, associate professor of medicine at New York Hospital-Rockefeller University in New York City. He described five patients with clinical symptoms of AIDS or AIDS related complex and low CD4 counts. The patients had repeatedly tested negative for HIV-1 and HIV-2. All five were from New York City, and only one was in a high risk group for HIV infection—a sexually active young gay man.

Dr Curran said that the CDC was investigating six other cases of moderate to severe immunodeficiency in five men and one woman. One of the men was gay, and two had received transfusions or transplants. These too were negative for HIV-1, HIV-2 and human T cell leukaemia/lymphoma virus on repeated testing.

Dr Luc Montagnier, the French AIDS researcher, reported the same findings in two patients. In addition, Dr David Ho of the Aaron Diamond AIDS Research Center at New York University Medical Center said that he was studying 11 cases of immune deficiency with low CD4 counts, mostly in gay men. "I'm confident, based on the serology and PCR [polymerase chain reaction], that this is not HIV-1 or 2."

By the end of the session doctors had reported about 30 cases of the mysterious immune deficiency to a stunned audience. Some of the patients were in high risk groups, but by no means all. Of particular interest was an American woman with T cell deficiency and *Pneumocystis carinii* pneumonia. She was HIV negative but had received donated blood in 1950. Dr Curran

cautioned, "It's so easy to slip into calling this immunodeficiency AIDS. It's not AIDS until it's proved. In the past two or three years, we've seen a dozen or two dozen cases, but the cases don't seem to cluster in risk groups, and they were reported from four different states."

Scientists at the conference noted that severe immunodeficiency can be caused by a variety of other diseases and agents. These include cancer, drugs, and some environmental factors. The possibility of a new retrovirus causing an AIDS-like disease has serious implications for the supply of safe donated blood. Scientists tried to reassure the public that the blood supply in any country that conducts standard screening was still safe. Journalists at the conference wondered how they could be so confident.—JANICE HOPKINS TANNE, contributing editor, *New York*

Court says doctors were right to treat Jehovah's Witness

Three Appeal Court judges ruled last week that doctors could lawfully continue giving blood to a critically ill 20 year old woman despite her refusal to accept transfusions. The woman refused because she had been brought up as a Jehovah's Witness. Jehovah's Witnesses base their refusal to accept blood transfusions on a literal reading of biblical text.

The case was the first in the English courts to raise the issue of an adult's right to refuse lifesaving treatment. It has important implications for doctors, reminding them that they should ensure that a patient who refuses treatment is properly informed of the consequences and is not reaching the decision under someone else's influence. Lord Donaldson, master of the rolls, said: "Treatment in accordance with whatever doctors think is in the best interests of the patient is authorised."

The woman, named only as T to protect her identity, was brought up by her mother, described as a fervent Jehovah's Witness, after her parents divorced. She rebelled against her mother's faith when she was 17 but had said that she still retained some of the sect's beliefs.

Lord Donaldson, Lord Justice Butler-Sloss, and Lord Justice Staughton were told that T was in a critical but stable condition, heavily sedated and on a ventilator in an intensive care unit. Three days after being in a car accident she was admitted to hospital with a suspected chest infection. Thirty four weeks pregnant, she went into labour. Before undergoing a caesarean section, which resulted in a stillbirth, she signed a form refusing blood transfusions. After the operation her condition deteriorated and her father, who is not a Jehovah's Witness, won a High Court declaration authorising doctors to administer blood. T has been receiving blood and plasma since the order.

Last week's appeal against the order was brought by the official solicitor, David Venables, who acts for those involved in court cases who are unable to instruct lawyers themselves. His counsel, James Munby QC, argued that adult patients of sound mind had a basic human right, protected by the common law, to refuse medical treatment, even in the face of death. The decision in T's case leaves that principle of law intact. In several cases involving the children of Jehovah's Witnesses doctors have used wardship to get a court's sanction for transfusions. But several adult Jehovah's Witnesses have died after refusing blood transfusions.

T's case shows that there may be scope for challenging the validity of a patient's refusal—for instance, on the grounds that wrong information was given, the emergency that arose was not foreseen, or the decision was influenced by a relative or friend.

The court heard that T said "out of the blue" while her mother was visiting her in hospital that she did not want a blood transfusion, before anyone had raised the subject. Lawyers for T's father and the two health authorities in the West Midlands responsible for her treatment contended that her refusal was invalid because she did not foresee that her life would be in danger, she was misinformed about possible substitutes for blood, and she was acting under her mother's influence. Mr Justice Ward said in his judgment: "The pressure of her mother, the very presence of her mother, the mother's fervent belief in the sin of blood transfusions, the patient's desire to please her mother despite their troubled relationship—all this contributed to the focus of attention being drawn to a blood transfusion before anyone else had even contemplated its need."—CLARE DYER, legal correspondent, *BMJ*

The Week

Sex, scandal, and fraud

The *Wall Street Journal* last week characterised the affair of David Mellor, the minister for culture and sport, and the actress as a story for the silly season, when newspapers have nothing better to fill their pages with than errant cabinet ministers and cossetted racing pigeons. But the *Wall Street Journal* has it wrong. This story and others like it are the staple of many British newspapers. And they matter because they distract the press from the real job of ferreting out genuine abuses of government.

It is reminiscent of the accusations that used to be levelled against the General Medical Council. The council, it was argued, was more bothered if a doctor went to bed with his patient than if he killed her through incompetence. The GMC's proposed new procedure for performance review is trying to address that concern. In particular the GMC's president, Sir Robert Kilpatrick, has consulted informally on the procedure, building, it seemed, a consensus of support. Now that the procedure has gone out for formal consultation, however, the doubts have started to emerge. Last week both the Joint Consultants Committee and the General Medical Services Committee voiced worries about the costs, about retraining doctors, and about the dangers of encouraging complaints.

For one of its activities, however, the GMC is getting credit: its tough stance on scientific fraud. Last month another doctor was struck off for fabricating data in a drug trial performed for a pharmaceutical company. The doctor, a general practitioner, claimed to have recruited five patients. He was found guilty of having improperly completed the data on four of them. His was the eighth case to have come before the professional conduct committee in the past four years, and all eight have so far been found guilty of serious professional misconduct. Another 18 cases are at various stages in the GMC's procedure.

What is common to all these cases is that they have been referred to the GMC by the companies concerned in conjunction with the Association of the British Pharmaceutical Industry. Indeed, there seem to be no other cases of scientific fraud before the GMC that have not come via this route. There are two reasons for this. Firstly, the rules of good clinical research practice in the pharmaceutical industry demand such close monitoring that it would take a sophisticated fraudster to evade scrutiny. (And some of the frauds have not been sophisticated: in one case assessment forms were dated before the drugs were supplied and in another after the visit at which they were to be checked.) The other reason is that the Association of the British Pharmaceutical Industry has, under the guidance of its medical director Frank Wells, taken a tough stance on fraud.

The GMC's latest annual report mentions scientific fraud for the first time, but there's one conclusion it doesn't draw. It seems odd that the only people doing fraudulent work are those doing drug trials. The small but steady stream of cases coming from the pharmaceutical industry raises questions for other research communities: about their procedures for monitoring the quality of research work and about the toughness of their attitude towards fraud.

HART