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## Africans die in pain because of fears of opiate addiction

**Dorothy Logie** NAIROBI

Attempts to improve palliative care services in Africa are being hampered by the fear that many African professionals have of using morphine therapeutically and by poor access to the drug, a conference was told last month.

Many countries in Africa have no access to morphine so that palliative care is reduced to the level of supportive care without pain relief, delegates from 35 countries heard. They were attending the second palliative care conference for Africa, in Nairobi.

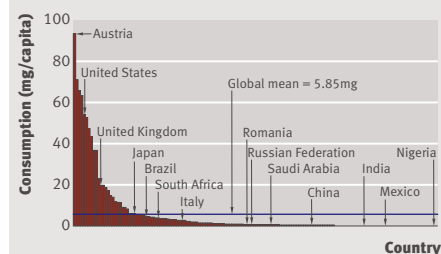
While the world's 20 richest countries consume 86% of global therapeutic morphine, countries such as Rwanda use just 0.039 mg per capita, one of three lowest users in the world.

Opiophobia—the fear of using morphine therapeutically—is a big obstacle facing palliative care services in the continent, the conference heard.

Fear of addiction, excessive bureaucracy, inadequate requisitioning, and a reluctance to use oral morphine outside hospital are widespread throughout Africa. In addition, the lack of doctors, especially in rural areas, makes nurse led prescribing essential, but there is an unwillingness to encourage nurses to take on the prescribing of morphine. At the same time the need for palliative care services is growing.

Cecelia Sepulveda, head of the cancer control programme at the World Health Organization, said that cancer is generally a neglected area in resource poor countries.

### GLOBAL CONSUMPTION OF MORPHINE, 2003



Source: International Narcotics Control Board



LINDA DAVIDSON/THE WASHINGTON POST 2007/REPRINTED WITH PERMISSION

Deamonte Driver, right, who died in February after a dental abscess spread to his brain

## Future of US children's health insurance still uncertain

**Janice Hopkins Tanne**

NEW YORK

The US State Children's Health Insurance Program, subject of a fight between President George Bush and Congress, was extended to 16 November.

The programme was to expire on 30 September, the end of the government's fiscal year and the end of the programme, which began 10 years ago and needs renewal every five years.

Congress passed a "continuing resolution" to extend it and several other programmes.

The current programme, funded partly by the federal government (about 70%) and partly by the states (about 30%), covers more than six million children. The expansion would cover another four million. Last month Congress

voted to renew and expand the programme to cover more children in families with incomes too high to qualify for Medicaid insurance, but too low for them to afford private health insurance.

The Congressional plan would cost an additional \$35bn (£17bn; €25bn) over the next five years. Proposing a more modest expansion, Mr Bush said that he would veto the bill as it stood, but he had not done so as the *BMJ* went to press.

He said it was a step towards socialised medicine and would cause children to be taken out of private health insurance to be covered under the federal state programme (*BMJ* 2007;335:637 and *BMJ* 2007;335:62-3).

A presidential veto can be over-ridden by a two thirds vote in both houses of Congress.

A combination of Democrats and Republicans who support the Bill have enough votes to over-ride a veto in the Senate, but they are about 24 votes short in the House. The fight for children's health insurance became emotional in the media last week. The BBC described Deamonte Driver, who died from a tooth infection that spread to his brain. His mother couldn't find a dentist who would accept Medicaid payment and couldn't afford to pay for the extraction herself (<http://news.bbc.co.uk>, 28 Sep, "Boy's death highlights US health debate").

The American Medical Association and AARP (formerly the American Association of Retired Persons), supported expanding the programme, to be funded by an increase in the cigarette tax.

## Netherlands considers introducing preconception care

**Tony Sheldon** UTRECHT

The Health Council of the Netherlands, a scientific advisory body, has recommended that the Dutch government introduce an integrated programme of preconception care, to reduce perinatal mortality, miscarriage, premature birth, and congenital abnormalities.

The Dutch government commissioned the council to draw up its advice because the Netherlands has lost its pre-eminent position on perinatal mortality

compared with other European Union countries, partly because of a higher proportion of older mothers and mothers belonging to ethnic minorities (*Ned Tijdschr Geneesk* 2004;148:1855-60).

The council's key message is that current antenatal care, which starts at the eighth week of pregnancy, can miss chances to improve the health of the mother and child. Information on health interventions should be brought forward until at least a month before any planned conception to allow the health benefits a chance to

have effect, it says.

The proposal also advocates an "integrated, multidisciplinary approach," in which all existing individual strands of care would be brought together with the same staff. These strands would include advice on diet, alcohol, and tobacco; genetic factors; chronic health conditions; current medication; and occupational health.

The measures recommended range from abstaining from tobacco, alcohol, and other recreational drugs to ensuring adequate intake

of folic acid and vitamin D. Health professionals will also check for rubella antibodies; ensure diabetic women's blood sugar is under control; recommend that women with epilepsy adjust or phase out drugs completely; and treat any sexually transmitted infection.

Some measures, such as campaigns for the use of folic acid, would target all women of child bearing age; others would target individual prospective parents.

**Preconception Care: a Good Beginning** is available at [www.gr.nl](http://www.gr.nl).

## UK does well on giving information to patients but poorly on access to new treatments

**Rory Watson** BRUSSELS

The United Kingdom ranks only 17th out of 29 countries in the latest edition of the Euro Health Consumer Index of public healthcare systems—one place behind Ireland and narrowly ahead of Italy and Portugal. It has slipped from 15th position last year.

The rankings, now in their third year, were produced by the Brussels based analysis and information organisation, Health Consumer Powerhouse. They are based on 27 indicators grouped into five categories—patients' rights and information, waiting times, outcomes, the generosity of public healthcare systems, and access to medication.

The UK, with its electronic patient records, quality ranking of hospitals provided by the Healthcare Commission, and 24 hour telephone healthcare information system provided by NHS Direct is in the forefront of patient access to information. However, it scores badly on access to new treatments and long waiting times, receiving only 581 points out of a potential 1000.

Arne Björnberg, the index's director, said that "Patients in the UK have the right to expect more. Despite substantial funding increases, the UK is still a mediocre overall performer."

Top slot with 806 points went to Austria, which scored consistently well across the five categories. The Netherlands, which topped

the league in 2006, is in second place, closely followed by France, Switzerland, and Germany. At the bottom of the table are Latvia, Bulgaria, and Poland.

In the individual categories Denmark was the winner on patients' rights and information; Belgium on waiting times; Sweden on outcomes; Finland, France, Hungary, and Sweden on generosity of systems; and Denmark, Ireland, the Netherlands, Spain, Sweden, and Switzerland on access to medicines.

In general, the survey found that increasing attention is being paid to patients' rights and that healthcare provision is improving. However, it notes that methicillin resistant *Staphylococcus aureus* infections in hospitals seem to be

spreading and that half of the health services delay consumer access to new medicines.

In the debate between the Bismarck healthcare system, based on social insurance with many insurance organisations, and the Beveridge variety, where financing and provision are handled in one organisational system, as in the UK, the survey indicates that the former delivers better value.

"It is very hard to avoid noticing that the top five countries, which fall within 36 points on a 1000 point scale, all have dedicated Bismarckian healthcare systems," the report says.

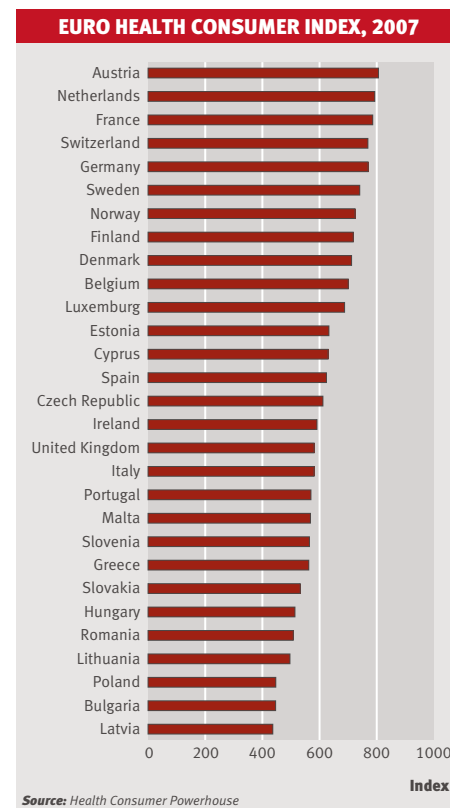
Commenting on the table, John Appleby, chief economist at the King's Fund, said,

"These composite performance tables are problematic. One of the problems is that different weighting has to be given to different components, according to what is thought to matter to patients. But that is often hard to know."

See [www.healthpowerhouse.com](http://www.healthpowerhouse.com).



**The Bismarck system beats the Beveridge one, the report says**







TRAVELSHOTS/SALAWY

Current antenatal care starts too late to maximise chances of good health for mothers and babies

## Court upholds demand for preimplantation genetic diagnosis

Fabio Turone MILAN

The battle on assisted reproduction and prenatal diagnosis in Italy took a new turn last week, when the gynaecologist Giovanni Monni, head of the obstetrics and gynaecology department in the Ospedale Microcitemico in Cagliari, Sardinia, was ordered by the local court to provide preimplantation genetic testing to a couple carrying the gene for  $\beta$  thalassaemia, which is common on the island.

Dr Monni, the current president of the Italian Association of Hospital Gynaecologists, had unwillingly obeyed the controversial law approved in 2004, which, through guidelines, forbids preimplantation genetic diagnosis, even though he personally supported the couple's request for it (*BMJ* 2004;328:9). "I am very glad of the court's decision," he told the *BMJ*.

The law contains several points that have been opposed from the beginning by almost all gynaecologists. These include the stipulations that assisted reproduction techniques can be used only by sterile heterosexual couples in a "stable relationship"; that embryos cannot be frozen, which means that a maximum of three fertilised eggs must be immediately implanted in the womb; and that sperm and eggs cannot be donated. In addition only the non-invasive "observation at the microscope" is allowed as a form of preimplantation testing.

The constitutional court had rejected in November 2006 a similar request for preimplantation genetic diagnosis by the same couple. The ban on genetic testing, the court argued, was contained in the guidelines defined by the health ministry and not in the law itself. Consequently the law itself was not at variance with the constitutional right to health. After that pronouncement the couple went back to the lower court and sued Dr Monni and the hospital and received the recent favourable judgment.

Meanwhile, the couple at the centre of the controversy started treatment for in vitro fertilisation and preimplantation diagnosis at a private centre in Istanbul, with expenses paid for by two anonymous donors.

Now the woman, Simona, who had two abortions in the past, is already pregnant, but she has said that she will implant the embryos frozen in Italy as soon as possible, after the end of her present pregnancy, if they do not carry the genes for  $\beta$  thalassaemia.

Many specialists have predicted that the law would have several adverse consequences. They said it would reduce success rates, increase the number of multiple pregnancies, and result in many Italian couples travelling abroad for treatment. The first official data support these predictions (*BMJ* 2007;335:62).

Moreover, many couples seem to be circumventing the ban on the freezing of embryos. According to journalistic reports, more and more couples are being allowed to freeze their embryos by refusing to implant them all in a written statement to the hospital.

The next step will be the publication of new guidelines.

**The court found that the ban on genetic testing was in guidelines not in the law itself**

## African-American leaders call for action on AIDS in US

Bob Roehr WASHINGTON, DC

African-American leaders launched a call to action to address HIV/AIDS in the black community at a Capitol Hill news conference last month. The aim is to halve the rates of new infections, reduce the stigma of AIDS, increase by a half both the number of people who know their HIV status, and who are receiving care for HIV infection.

"AIDS is a black disease no matter how you look at it—through the lens of gender, or sexual orientation, or age, socioeconomic class, education, or region of the country—black people bear the brunt of the epidemic," said Phill Wilson, executive director of the Los Angeles based charity the Black AIDS Institute.

"Some 30% of new cases among gay men are among black men; 40% of new cases among men are black; 67% of new cases among women are black; and 70% of new cases among youth are black. That is why we are calling on this mobilisation."

"Why are more than 50% of new HIV cases occurring within the African-American community when we are only 13% of the people?" asked Mohammad Akhter, executive director of the National Medical Association, which serves doctors and patients in the black community.

"We need to reassess the national strategy on HIV/AIDS to see why it is not working. If 50% of the new cases of HIV are in the African-American community, shouldn't that be where 50% of the resources should be going?" Dr Akhter said.

Mr Wilson acknowledged that earlier efforts to rally the black community to fight HIV/AIDS have fallen short. "The reason why I think this is different is that it is the first time there is a national coordinated effort of all sectors."

**Magic Johnson announced he was HIV positive in 1991**



JED/JACOBSOHN/GETTY IMAGES

## GMC guidance on conscience goes too far, says BMA

Clare Dyer *BMJ*

The BMA has clashed with the UK General Medical Council about draft guidance from the GMC for doctors who object to providing certain medical services on the ground that they conflict with their personal beliefs.

In its response to the draft of *Personal Beliefs and Medical Practice* the BMA argues that the guidance goes beyond doctors' widely accepted right to opt out of certain procedures that involve matters of life and death, such as abortion, contraceptive services, and the withdrawal of life prolonging treatment. The association claims it could confuse patients and give doctors a licence to discriminate.

But the GMC insists that the draft guidance does not contradict current guidelines in its core text, *Good Medical Practice*, which does not limit conscientious objections to life and death matters. It says that the new guidance is intended to supplement *Good Medical Practice* by giving more detailed and practical information in response to growing numbers of inquiries about matters of faith and other areas of personal belief.

The BMA said the draft advice seemed "to extend the right of conscientious objection to any procedure with which doctors have a moral, cultural, or religious disagreement." The association called for a limited list of clearly defined procedures to which doctors would be entitled to conscientiously object.

Tony Calland, chairman of the BMA's medical ethics committee, said, "Doctors are not there to judge patients but to treat them."

The BMA's response is at [www.bma.org.uk](http://www.bma.org.uk)

## Medical Research Council appoints new chief executive

Roger Dobson *ABERGAVENTNY*

Sir Leszek Borysiewicz, who was knighted for his research into developing vaccines, is the new chief executive of the UK Medical Research Council (MRC).

The deputy rector of Imperial College, London, is to take over from the current holder, Colin Blakemore, whose term of office finishes at the end of this month.

"I'm excited by the chance to work across the whole spectrum of biomedical science and to help to make a difference in relation to healthcare for individuals in the UK and globally," said Professor Borysiewicz.

He joined Imperial College London in 2001 as principal of the faculty of medicine before becoming deputy rector three years later. His research interests are in viral immunology, infectious diseases, cell mediated immunity, virus associated malignancy, and vaccine development. He was knighted in 2001 for his research into developing vaccines, including one to stop the development of cervical cancer.

He holds a number of appointments in higher education and science and was recently made a governor of the Wellcome Trust. He is also the chairman of the UK Clinical Research Collaboration's integrated academic training committee and chairman of the joint scientific advisory board of the MRC and the UK Stem Cell Foundation. He is a founder fellow



Sir Leszek Borysiewicz

of the Academy of Medical Sciences.

Sir Leszek's appointment comes in the wake of Sir David Cooksey's recommendation last year of a single strategy for health research in the UK and the formation of an Office for the Strategic Coordination of Health Research (OSCHR) to oversee this strategy.

"What the Cooksey report has done is to open the door on a plethora of opportunity that exists. It's not just

an opportunity on the translation side, people forget that Sir David's review also very firmly identified the need to maintain the basic research agenda as the seed corn from which all future proposals are going to flourish."

He added, "We have a lot of work to do with the Department of Health's National Institute for Health Research to build up the applicability of discovery into changes both in clinical practice and in drugs or other health interventions."

Sir Leszek studied medicine at the Welsh National School of Medicine and took his first consultant's post at Hammersmith Hospital, London. He has had a long association with the MRC. Early in his career he completed an MRC Clinical Training Fellowship, and between 1995 and 2000 he chaired the MRC Molecular and Cellular Medicine Board and served on the MRC Council.

**"I'm excited by the chance ... to make a difference in relation to healthcare"**



The new law should prevent disputes over the wishes of incapacitated patients, like the one that occurred in the Terri Schiavo case in Florida

## Patients win right to have their

Clare Dyer *BMJ*

A new statutory right for patients to say in advance what treatments they would want to refuse if they later lose the capacity to take decisions came into force this week.

Doctors will have to abide by the new advance decisions to refuse treatment (ADRTs) or risk criminal or civil proceedings in the courts.

The measure forms part of the

Mental Capacity Act 2005, which from October 1 also gives individuals the right to create a lasting power of attorney by appointing a trusted friend or relative to take healthcare decisions for them in the event that they become incapacitated.

Advance directives or "living wills" to refuse treatments are already binding under common law, but the act sets up a statutory framework that



# Trusts face spot checks if their treatment of elderly people gives cause for concern

Jacqui Wise LONDON

NHS trusts in the United Kingdom must ensure that older people are given care in a way that respects their dignity, and trusts will face spot checks where there is evidence for concern, the healthcare watchdog for England has warned.

The Healthcare Commission compiled a report from assessments at 23 NHS hospitals, surveys of 80 000 NHS inpatients, and nearly 130 000 NHS staff, the commission's analysis of 10 000 complaints, and information on safety incidents from the National Patient Safety Agency.

The 23 hospitals inspected were chosen because of concerns about levels of care. Although no serious breaches of government standards were found, only five of the trusts were found to have fully complied with all the standards

relating to dignity, privacy, and nutrition.

Eight trusts were given letters warning them that they were at risk of not meeting the standards and that they would be scrutinised carefully again next year. The remaining 10 trusts were told to make improvements.

The commission found that in some cases there were inadequate arrangements for providing privacy, such as curtains and locks on toilets and washing facilities. And although hospitals tried to avoid placing patients in mixed sex wards this still occurred, especially at busy times.

One in four complaints received by the Healthcare Commission was about poor nutrition.

See Observations p 698

*Caring for Dignity* is available at [www.healthcommission.org.uk](http://www.healthcommission.org.uk).



JEFF GREENBERG/ALAMY

Only five out of 23 trusts inspected because of concerns about care complied with all standards relating to dignity, privacy, and nutrition

## GMC says hospital at fault for failing to provide support

Owen Dyer LONDON

A consultant radiologist who failed to carry out breast examinations according to NHS guidelines was last week allowed to continue

working under conditions, after a General Medical Council fitness to practise hearing found his employer had failed to provide adequate resources and support.

Lan Keng Lun missed warning signs and failed to carry out standard procedures on Ms A, a patient referred to him after an abnormal mammography result in March 2003. She was diagnosed as having breast cancer seven months later.

The Epping NHS Breast Screening Service in Essex also failed to meet national standards in the breast screenings of eight other women, the GMC found.

But an external review commissioned by the GMC found that the Princess Alexandra Hospital NHS Trust, which oversaw the facility, shared much of the responsibility for the serious service failure in their breast screening service.

## advance decisions honoured by medical staff

aims to give doctors and patients greater certainty.

Patients will not be able to demand any particular treatment or require a doctor to do anything unlawful. NHS guidance on ADRTs says it should be made clear to a patient that artificial nutrition and hydration are considered treatment, while basic care, such as giving food and water by normal means, is not.

An ADRT can be oral or written but if it is refusing life sustaining treatment, the law requires it to be in writing, signed and witnessed, and to include a statement that it is to apply even when life is at risk.

Ben Lobo, a consultant physician and community geriatrician who chairs the East Midlands ADRT Project Team and has been asked to help produce national guidance,

said, "A valid advance decision has to be respected and acted upon by anybody including doctors, nurses, and ambulance staff. This new law will help to reduce stressful discussions between professionals and carers in times of medical crisis when the patient might be too ill to tell people. It will help people to die with dignity on their own terms."

Paul Farmer, chief executive of

the mental health charity Mind, said, "The Mental Capacity Act is an important development, introducing new safeguards to protect the rights of some of the most vulnerable people in our society. It gives people with mental health problems more control over their lives."

Guidance on ADRTs is available on the BMA's website and at [www.adrtnhs.co.uk](http://www.adrtnhs.co.uk).

## IN BRIEF

**Red Cross director acquitted of giving tainted blood:** The former director of the Canadian Red Cross, Roger Perrault, and three other doctors were acquitted on Monday after a criminal trial in which they were accused of giving tainted blood to thousands of people with haemophilia who became infected with HIV or hepatitis C.

**Eisai to appeal against court ruling on NICE:** Eisai, the company that holds the licence for donepezil (Aricept), announced last week that it would appeal against an English High Court ruling that upholds guidance from the National Institute for Health and Clinical Excellence (NICE) that denies the drug to NHS patients with mild Alzheimer's disease (*BMJ* 2007;335:319).

**Congo struggles with Ebola virus:** International efforts continued last week in the Democratic Republic of Congo to try to halt the spread of Ebola haemorrhagic fever. Of 24 confirmed cases, six people have died.

**Global Fund donors pledge \$9.7bn:** Donors to the Global Fund to Fight AIDS, Tuberculosis, and Malaria have given initial pledges worth \$9.7bn (£4.7bn; €6.8bn) in new funds—including \$1.27bn by France and \$729m by the United Kingdom—to combat the three diseases over three years.

**France acts on benefit deficit:** A non-reimbursable charge of €0.50 (£0.35; \$0.70) will be added to every box of drugs in France in a series of measures to reduce a predicted social security deficit of €11.7bn in 2007 and €12.7bn in 2008.

**Litigation payments for breast cancer care average £38 000:** About 2.4% of the total clinical claims received by the English National Health Service Litigation Authority relate to care of patients with breast cancer, according to a study covering 1995 to 2005. The highest payment was £634 194 (€911 575; \$1 293 782) and the average £37 928 (*Breast* 2007 Sep 24 doi: 10.1016/j.breast.2007.08.003).

**Smoking rises as a risk factor in cot deaths:** The prevalence of smoking during pregnancy among mothers of babies who suffered sudden infant death syndrome rose from 50% in the late 1970s to 80% in the period 2003-6, while the rate among expectant mothers in the general population fell from 30% to 20%, a new report says (*Early Human Development* 2007 Sept 18 doi:10.1016/j.earlhumdev.2007.07.011).

## NHS continues to flout rights of disabled people to health care

Zosia Kmietowicz LONDON

Campaigners have repeated their call for more to be done to meet the health needs of people with learning disabilities and mental health problems—who, they say, continue to be failed by the NHS in England and Wales.

One year after its damning report into the delivery of health care to disabled people, the Disability Rights Commission, the statutory watchdog organisation for people with disabilities in England, Wales, and Scotland,

says in a new report that little has changed to bridge the gap in health care.

Only two strategic health authorities in England—North East and South West—have developed adequate schemes to comply with new laws on disability equality that came into force in December 2006, says the report. Of the remaining eight, six have schemes that are unacceptable and two have failed to address the issue at all.

The report recommends that the Equality and Human Rights Commission, which took over the role of the Disability Rights Commission on 1 October, take legal action against those authorities that fail to produce acceptable schemes.

*Equal Treatment: Closing the Gap—One Year On* is available at [www.drc-gb.org](http://www.drc-gb.org).

## Doctors who give lethal injections should be punished, says Amnesty

Caroline White LONDON

Doctors and other healthcare staff who take any part in executions by lethal injection should be punished by their professional bodies, says the human rights organisation, Amnesty International.

In a report published to mark 25 years of the use of this method of execution, Amnesty says that leading professional organisations should push harder to outlaw the practice. The organisation opposes any form of capital punishment.

The practice is condoned in only six countries. But despite an overall fall in the numbers of lethal injections in four of these, it has become the execution method of choice in the United States, says the report.

There have been 919 such executions in

the US since the method became legal in 1977 to the end of July this year. More prisoners are executed in China than anywhere else in the world, and the country increasingly views lethal injection as a more modern approach than death by shooting, says the report.

There are no official figures, but about 40% of executions are thought to use this method, with possibly thousands carried out to date, says the report.

As a procedure that involves a degree of medical expertise, lethal injections put pressure on doctors to take part, "raising serious ethical and human rights issues," says Amnesty.

*Execution by Lethal Injection: A Quarter of a Century of State Poisoning* is available at [www.amnesty.org](http://www.amnesty.org).



A prisoner is executed by lethal injection in Guatemala in June 2001

AFP/GETTY IMAGES

# Australian efforts to tackle abuse of Aboriginal children without consultation raise alarm

**Melissa Sweet** SYDNEY  
Aboriginal people in the Northern Territory (NT) are facing considerable changes to their lives, including loss of control of their lands and withheld welfare payments, as part of extensive new policies aimed at tackling the sexual abuse of children.

The Australian government's "national emergency response" to an inquiry into the sexual abuse of indigenous children in the territory also involves widespread restrictions on alcohol, the abolition of a community employment scheme, and a ban on X rated pornography.

The government initially also announced plans to conduct compulsory checks on the sexual health of Aboriginal children, but after an outcry from health and medical groups it is now organising optional general health checks.

The intervention, announced on 21 June without consultation with indigenous or medical groups, was followed by the rushed passage in August of enacting legislation. It has provoked alarm among many indigenous and public health experts as well as human rights and legal groups.

There is widespread support for some long overdue political attention to the problem of child abuse, which many reports have documented over the past 20 years. Some aspects of the intervention, including the provision of extra police and health services, are also generally supported.

But many experts are concerned that overall the NT intervention, as it is called, may do more harm than good by undermining Aborigines' control over their lives and connection to their land.

Pat Anderson and Rex Wild, QC, the authors of the report *Little Children are Sacred*, which prompted the intervention, told a recent forum on indigenous health that their 97 recommendations bore little relation to the government's response. Indeed their first recommendation emphasises the importance of "genuine consultation" with Aborigines.

Ngiare Brown, a prominent indigenous doctor at the Menzies School of Health Research, in Darwin, told the forum at the Garma festival, in Arnhemland, that the "punitive" intervention had been developed "in a complete policy and strategic vacuum"; violated the principle to first do no harm; and had left many families and communities frightened.

"We don't empower people by removing their control," Dr Brown said. "We don't overcome poverty by stripping them of their land and assets. It is patent fiction to link land rights to child protection."

A spokesman for the Australian Indigenous Doctors' Association, which represents

**"The report called not for the declaration of war ... but for a thoughtful consultative process that stands some chance of leading to change"**

about 120 doctors and 120 medical students, told the *BMJ* that the intervention was making many Aborigines "worried sick."

The Congress of Aboriginal and Torres Strait Islander Nurses also warned that the intervention was creating "fear, confusion, and uncertainty." It ignored international evidence about the importance of land rights



A child takes part in the Garma Festival in Arnhemland, Northern Territories

MITCHELL WARD/YOTHU YINDI FOUNDATION/GARMA FESTIVAL

and community controlled services in improving health, tackling social inequality, and developing successful indigenous communities.

"Children are being used as an excuse for an intervention that is disempowering the very communities it purports to assist," the congress said in a statement issued at its conference in Alice Springs last month.

Fran Baum, a commissioner in the World Health Organization's Commission on the Social Determinants of Health and professor of public health at Flinders University, in Adelaide, said that the government had used "a report that bravely named and respectfully described the problem of child sexual abuse to launch what is seen as an offensive, an attack, an assault on fragile Aboriginal communities.

"[The] report called not for

the declaration of war, with its echoes of domination and crisis, but for a thoughtful consultative process that stands some chance of leading to meaningful change," she said. "The report recognised that there has to be change but that this was only likely if Aboriginal people are listened to and respected—the basis of any functional relationship."

Concerns are widespread that the intervention, announced in a heated pre-election climate, will not translate into long term sustainable solutions despite its likely billion dollar cost.

Oxfam Australia said the lack of consultation raised questions about the intervention's likely impact. "It would have had a greater chance of sustainable success if there'd been a fuller engagement with Northern Territory Aboriginal people," the agency's executive director, Andrew Hewett, told the *BMJ*.