# New authority to monitor xenotransplantation experiments

Jacqui Wise, *BMJ*

The British government is to set up a regulatory authority to monitor all research into xenotransplantation—the transplantation of animal tissue into humans. Human trials will not be allowed to go ahead until there has been more research into aspects of physiology, immunology, and the risk of infection.

Health secretary Stephen Dorrell accepted the main recommendations of the advisory group on the ethics of xenotransplantation headed by Ian Kennedy, professor of medical law and ethics at King's College, London. He announced the establishment of the Xenotransplantation Interim Regulatory Authority, which will be chaired by Lord Habgood of Calverton. The authority will regulate developments until there is a suitable opportunity for primary legislation.

The advisory committee's report *Animal Tissue into Humans* concluded that xenotransplantation could be ethically acceptable if certain conditions were met. It states that it would not be ethically acceptable to use primates as a source of materials for xenotransplantation, mainly because they would be exposed to too much suffering.

Pigs, however, would be an acceptable source of material, provided that there is only limited genetic modification. Also, the genetic distance of pigs from humans means that fewer of the viruses present will be infectious to humans and so pose a much lower risk than if primates were used. The report is broadly in line with that produced by the Nuffield Council on Bioethics last year (16 March, p 65).

Attempts at xenotransplantation have been made sporadically over the past 100 years, but all have failed after a few months at most. The main stumbling block to progress has been hyperacute rejection. In the past seven years there have been major advances in this field, and laboratory evidence and some primate work have shown that this powerful immune reaction may be overcome. Although these breakthroughs have generated much media publicity, little research has been published in peer reviewed journals.

There are still many more hurdles remaining, and the report says that there needs to be more research on transplant function, organ growth, the functioning of the recipient's immune system, and other aspects of immunological rejection. The committee estimates that gathering this extra research information could take around 18 months.

IMUTRAN

**Pigs would be ethically acceptable as a source material**

The report says that the transfer of viruses to humans causes the most concern, particularly as some porcine viruses may not yet have been identified. Herb Sewell, professor of immunology at Queen's Medical Centre, Nottingham, and a member of the advisory committee, said that transplanting living tissue from animals to humans provided a "unique opportunity" for viruses to jump the species barrier. "Not only could this lead to particular infections in the patient, but the patient may pass on the infection to the rest of the public," he said.

In the United Kingdom the biotechnology company Immutran is developing genetically modified pigs for use as source animals for xenotransplantation, and it intends to move to human trials in the next 12 months. The company welcomed the report but urged swift progress on the establishment of the regulatory authority.

Xenotransplantation causes concern because living tissue is used; porcine insulin and heart valves can be used safely as they are extensively treated first. The interest in xenotransplantation stems from the large shortfall in the supply of donated organs for transplantation compared with the demand.

There will be a three month consultation period on the government's response (see p 242). □

*Animal Tissue into Humans* is published by the Stationery Office (tel: 0171 873 0011).

The move to set up a regulatory body for xenotransplantation in the UK illustrates the contrast between current UK and US thinking.

The British government has endorsed the establishment of a regulatory body to monitor scientific developments, to check on research, including deciding whether a human trial can take place, and to take account of the ethical concerns of the public. This will act in a similar way to the Human Fertilisation and Embryology Authority.

In the United States antiregulation forces both in Congress and in the private sector have apparently influenced the debate, and draft public health service guidelines and a report from the Institute of Medicine both leave regulation effectively to local bodies.

Professor Albert Weale, chairman of the Nuffield Council on Bioethics working party, said: "There is a gap opening up between the US and UK on attitudes towards regulation of xenotransplantation, and this is worrying because of the risk of transmission of viruses." He warned that one consequence may be that companies will simply carry out the research in countries with more lax regulation. "We need to have urgent action on an international level," he said.

Jonathan Allen from the Southwest Foundation for Biomedical Research in Texas writes in *Science and Engineering Ethics* (1996;2:486-90): "More lax guidelines in place in the United States will, in effect, jeopardise the health of individuals not only in the US but also globally as we have seen with the rapid worldwide spread of HIV-1."

## *In brief*

**BMA goes on the Internet:** The BMA has launched a 130 page web site on the world wide web for doctors and members of the public to access information about the organisation. The site is at http://www.bma.org.uk

**Antiabortion violence rising:** Violent acts against abortion clinics in the United States have been rising in the run up to the 24th anniversary of Roe v Wade, the Supreme Court decision to legalise abortion. On 16 January two bombs exploded at an abortion clinic in Atlanta, Georgia, injuring six people.

**Campaign to reduce childhood iron poisoning starts in United States:** The Food and Drug Administration has ruled that all iron containing drugs and supplements must be placed in child proof containers and display prominent warning statements. Pills containing 30 mg or more of iron must be individually blister packed.

**French officials charged with poisoning:** Two former officials of the central pharmacy of Paris have now been charged with poisoning for having allegedly distributed growth hormone knowing that it could be contaminated with the agent responsible for Creutzfeldt-Jakob disease (18 January, p 166).

**Chagas' disease virtually eliminated in Brazil:** Chagas' disease is a chronic and incurable parasitic disease that can cause disability and even death. The WHO said that Brazil accounted for over 40% of the prevalence of the disease.

**EU approves labels on genetically modified foods:** The European Union has said that genetically modified foods and processed foods containing genetically modified ingredients must be labelled as such. But products with genetically modified ingredients that are deemed to be "chemically identical" to conventional foods do not need labelling. Campaigners say that this loophole means 80% of genetically altered foods would not be covered by the regulation.

# Hay fever drug to be banned by the FDA

Deborah Josefson, *Norwalk, Connecticut*

The United States Food and Drug Administration (FDA) has announced that it plans to ban terfenadine, a popular antihistamine which has been on the market since 1985.

In 1992, however, it became known that terfenadine may cause prolongation of the QT interval and trigger fatal ventricular arrhythmias. This side effect is seen when the drug is taken concomitantly with the antibiotics erythromycin and clarithromycin and with the antifungals ketoconazole and itraconazole. Patients with liver disease are also prone to this hazardous side effect.

The FDA has documented 40 cases of serious cardiac dysrythmias and 17 deaths associated with the drug. Despite this, terfenadine remained on the market because its non-sedative properties were thought to outweigh its risks. An aggressive educational campaign was launched by the FDA and Hoechst Marion Roussel who manufacture Seldane—one of the most popular brands. Doctors and patients were warned of the potentially dangerous drug interactions by means of product warning labels and letters to practitioners.

In a statement to the press, the FDA said: "Although these efforts have reduced inappropriate prescribing and dispensing of terfenadine with other drugs, such events have not been and certainly cannot be entirely eliminated."

The FDA's move was prompted by the availability of newer and safer antihistamines. One of them, fexofenadine (Allegra), is an active metabolite of terfenadine and was approved in the US in July 1996. Dr Robert Temple, an FDA official, said that his agency is acting because with safer alternatives available "there is a potentially lethal but infrequent risk that you can safely avoid."

A spokeswoman for the UK's Committee on Safety of Medicines said: "We are aware of the FDA's actions but we have no plans to follow suit." She added that fexofenadine was not available in the UK.

Hoechst Marion Roussel spokesman Charles Rouse said that his company will challenge the FDA action because it considers Seldane an exceptionally safe drug when properly prescribed. "Many people have taken the drug for 10 years and done fine with it," he said. The companies have 30 days in which to appeal the decision. □

# ECT clinics are below standard

Jacqui Wise, *BMJ*

**An audit of 53 clinics that carry out electroconvulsive therapy (ECT) in England and Wales shows that 70% are below standard.**

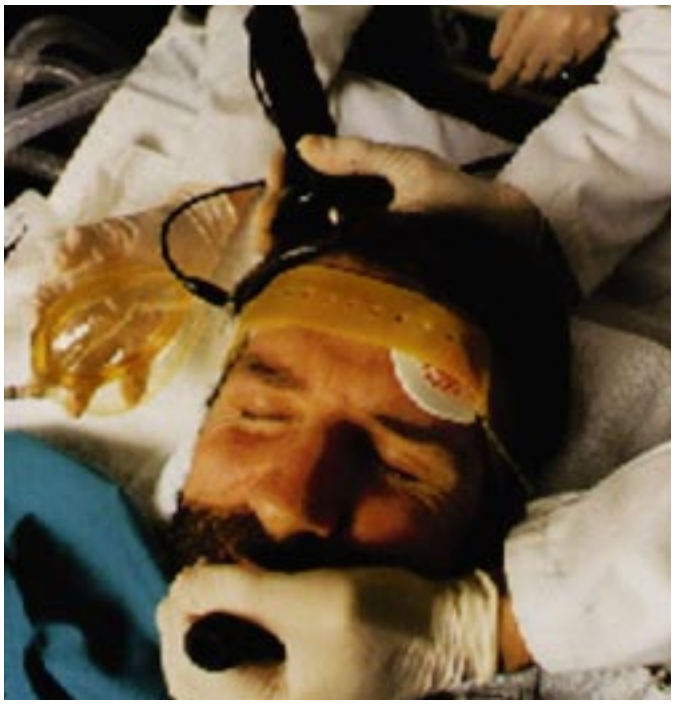
**The research, carried out by the Royal College of Psychiatrists and presented at its winter meeting in London this week, found that 16 clinics were rated as good or exemplary, 26 as deficient in some area of practice, and 11 as poor. Half the clinics visited were not using machines currently recommended by the college, and two thirds of the doctors giving ECT were senior house officers in psychiatry or GP vocational trainees.**

**The authors, Dr Richard Duffet and Dr Lelliot from the college's research unit, conclude: "The present practice of junior doctors, many with only six months experience in psychiatry, delivering ECT with minimal supervision is unsatisfactory." They suggest that a system of accreditation of doctors who deliver ECT may be needed to improve standards.**

**The Royal College of Psychiatrists produced standards for the provision of ECT in 1995. This report is the third large scale audit of the treatment covering supervision and training, equipment, and anaesthetic practice. It shows that there have been improvements since the last audit in 1991.**

**The mental health charity Mind criticised the audit for including only 53 clinics. It is calling for a more comprehensive and government led audit to cover in addition side effects, the effectiveness of treatment, and the quality of information given to patients before treatment.**

**Judi Clements, Mind's national director, said: "Every year an estimated 20 000 people are given ECT. With this many people I challenge the 'myth' that it is used as a treatment of last resort."** □



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**In the UK 20 000 people a year are given ECT**

# *E coli* inquiry calls for stricter laws on selling meat

Bryan Christie, *Edinburgh*

PAUL HACKETT

**Hugh Pennington hands over the report to Michael Forsyth**

Wide ranging measures have been proposed to improve the safety of food in Britain after one of the world's worst outbreaks of *Escherichia coli* food poisoning, which killed 17 people in central Scotland and affected a further 400.

The source of the outbreak was identified as a butcher's shop in the Lanarkshire town of Wishaw which had supplied contaminated cooked meat products to a number of retail outlets in the surrounding area (7 December, p 1424). A government inquiry set up to examine the outbreak has recommended that legislation be introduced to improve the way meat is sold to the public.

The inquiry team's interim report says that a national licensing system is needed to ensure that hygiene standards are being met in shops where both raw and cooked meats are sold. It is proposed that licences be withdrawn and shops closed down if they are considered to pose a risk to public health. At present only wholesale butchers are required to be licensed, but if the recommendation is accepted smaller shops would be required to train staff, have separate refrigerators and selling points for raw and cooked meats, and keep detailed records of product distribution.

An estimated 1000 shops in Scotland would be affected and perhaps as many as ten times that number across the United Kingdom. The Federation of Small Businesses said that many family butchers and village stores could be forced to close if these controls were brought in. Its spokesman Stephen Alambritis said: "Obviously it would be the death knell for them if they needed separate staff for raw and cooked meat." The government is to discuss the implications of the report with consumers, health professionals, environmental health officers, food processors, and retailers before arriving at a final decision on this recommendation.

The handling of the Lanarkshire *E coli* outbreak was the subject of considerable criticism, much of it relating to the delay in publicising a list of the outlets that had been supplied with suspect meat.

Politicians claimed current guidance is biased in favour of protecting commercial interests to the detriment of the public. The report acknowledges that in certain circumstances this may be the case and states that when consideration is being given to releasing information "the overriding requirement must be to protect public health."

The report also suggests ways in which outbreaks can be handled better. It recommends that outbreak control teams should be free to take decisions and carry out investigations independently of the health authority and local council that it relies on for support. It also highlights the importance of the team having a clear leader with the skill and experience to take appropriate decisions and suggests that in most cases this is likely to be the consultant in public health medicine.

The inquiry was led by Hugh Pennington, professor of microbiology at the University of Aberdeen and an international authority on *E coli* infection. Scotland has one of the highest rates of *E coli* 0157 infection in the world and has had two serious outbreaks in the past three years. The report recommends that research be carried out into the prevalence of *E coli* 0157 in Scottish cattle and into ways to improve the current DNA based methods for its identification. The report also said that the current data collection and surveillance system for tracking cases of *E coli* infection throughout the country should be improved.

The report has been welcomed in most quarters and is seen to have concentrated on the areas of greatest concern. The Scottish secretary, Michael Forsyth, said that he would act immediately on many of the recommendations, including commissioning an analysis of the information gathered during the outbreak and setting up an electronic reporting system to record data on food poisoning.

Professor Pennington will produce a full report next month after considering other issues such as cross contamination of carcase meat in abattoirs (see p241). □

The Pennington interim report can be obtained from the Scottish Office, St Andrews House, Edinburgh EH1 1DG.

# Move to bring back medical officer of health

Jack Warden,
*parliamentary correspondent, BMJ*

Two Scottish MPs have called for the restoration of the post of medical officer of health in the wake of the outbreak of *Escherichia coli* food poisoning in Scotland.

Dr Lewis Moonie, a former consultant in public health, and Sam Galbraith, a consultant neurosurgeon, have produced a paper, which has been referred by the Scottish secretary, Michael Forsyth, to the Pennington inquiry on the outbreak.

The Labour MPs argue in the paper that health authorities have become complacent about the threat from infectious disease, and they call for the restoration of the post of medical officer of health, who would have the skills and authority to take effective action in a public health emergency such as an outbreak of *E coli* infection.

Mr Forsyth said in the Commons that he was inclined to agree that one person should be in charge and that he or she should be a health professional, but this was a matter for Professor Pennington to reflect on further. He said that the proposal in the MPs' paper was well argued.

Drs Moonie and Galbraith argue that the *E coli* outbreak in Scotland shows how wrong it is to suggest that the infectious diseases that once killed so many people have been conquered by antibiotics, immunisation, and better social conditions. They point to the proliferation of drug resistant strains of tuberculosis, as well as to AIDS, salmonella, listeria, and now *E coli*. Moreover, they believe that the main killers today, heart disease and cancer, would respond better in the long term to preventive measures rather than the as yet limited attempts at cure.

The MPs assert that the abolition of the post of medical officer of health has been the most damaging of all the changes to the health service and that it is now time to think again. They suggest that the officer should be appointed by the secretary of state after local consultation and have the duty of writing an annual report on the public health in his or her area, to which NHS trusts and health authorities would be obliged to respond with action.

Similar powers and qualifications should apply to the government's chief medical officers. The MPs state that the practice of appointing chief medical officers with no formal training in public health should also be reconsidered. □

# French patient contracts AIDS from surgeon

Alexander Dorozynski, *Paris*

A French surgeon with AIDS has transmitted the disease to one of his patients. Until now only one similar case has been reported worldwide—that of a dentist in Florida who is believed to have contaminated five of his patients.

Dr Patrick Cohen of Saint-Germain-en-Laye, near Paris, a specialist in orthopaedic surgery and traumatology, is believed to have become infected with HIV in 1983 when he carried out a femoral prosthesis operation on a woman who had received several blood transfusions. At the time AIDS was still a rarity, and it was only in 1993 that Dr Cohen was diagnosed as having AIDS. For a year he unsuccessfully tried to have it recognised that he had been infected in the course of his work, and in 1995 he wrote to the ministry of health to ask that his former patients be informed and tested for HIV infection.

Out of more than 3000 former patients, 968 were found and accepted having a blood test. Only one of them, a woman, was found to be HIV positive. Dr Cohen had operated on her twice, in 1992 and 1993, and before the first intervention she was tested and shown to be HIV seronegative. During the second intervention, which Dr Cohen reported as having been lengthy and difficult, he pierced his gloves and injured his hands.

POUEDRAS AND PLAILLY EUREL OIS/SPL

**HIV positive surgeons should not practise invasive interventions**

The patient at the time received a blood transfusion from two donors who had been tested as HIV seronegative and remain so.

In December 1995 Professor Luc Montagnier, the man who discovered HIV, carried out an in depth molecular analysis of viruses isolated both from the blood of Dr Cohen and from that of his former patient. He concluded that the two viruses were very similar and that "a great probability existed that HIV transmission occurred between the two patients."

Professor Montagnier emphasises that such a contamination pathway was exceptional, mentioning an American study that did not find a single infection among 22 000 patients treated by seropositive health staff. But Dr Cohen was infected by 1983 and was not treated for 10 years, so at the time of the accident his blood must have been highly infective. He injured himself several times and his blood probably trickled into his patient's open wounds during the long haemorrhagic intervention.

Health authorities have agreed with recommendations made by Professor Montagnier last week to encourage healthcare staff to declare professional accidents, and they suggest that surgeons are screened for HIV after experiencing any wound that could lead to the transfer of potentially contaminating blood. Seropositive surgeons should refrain from practising invasive interventions and from complex procedures □

# Police could bug surgeries

Linda Beecham, *BMJ*

Doctors' leaders in Britain are worried about changes in surveillance techniques proposed in the Police Bill, which is going through the House of Lords.

In a letter to the *Times* eight doctors, including the president of the General Medical Council and the chairmen of the Academy of Royal Colleges, the council of deans of United Kingdom medical schools, and the council of the BMA, point out that the bill would give the police statutory powers to break into medical premises, install listening devices, and intercept and monitor telephone conversations between doctors and patients. By making the use of surveillance techniques statutory, any informaton picked up would have been obtained legally and be admissible in court.

During the report stage of the bill on 20 January the Lords voted that circuit judges should be given the responsibility for sanctioning bugging. And a further amendment would force chief police constables to obtain permission from a special commissioner before being allowed to carry out electronic surveillance in people's homes. The Home Secretary, Michael Howard, refused to accept that the police should seek prior approval and the government will try to overturn the amendments in the House of Commons.

The *Times* letter emphasises that the medical profession supports the fight against serious crime but that any infringements of the confidentiality between doctors and their patients could be justified only in the rarest circumstances. □

# Surrogate mother refuses to give up baby

Clare Dyer, *legal correspondent, BMJ*

**Police are considering a possible charge of obtaining money by deception against a 29 year old British surrogate mother who refused to hand over a baby commissioned by a childless couple.**

**Angela Richardson was arrested and released on bail by Derbyshire police after a complaint from Greg and Deborah White from Claverton in Somerset. The divorced mother of two from Derby was allegedly paid £4000 ($6000) to have the child for the Whites but decided to keep him when he was born last August.**

**Miss Richardson had simultaneously been in touch with two surrogacy organisations. She underwent artificial insemination for the Whites in November 1995 through Childlessness Overcome Through Surrogacy. The following month she flew to Stockholm to be inseminated for a Swedish couple under the aegis of the Surrogacy Parenting Centre. She reportedly told the Swedish couple that the baby was lost.**

**Mr White was told that the baby, Isaac, was his, but Miss Richardson had decided to keep him. But, his birth in August, a month before the expected date, raises the possibility that Miss Richardson may already have been pregnant when she underwent the insemination.**

**The case has prompted calls for legislation, but the ordinary criminal law on deception is quite capable of dealing with situations in which a would-be surrogate mother deliberately sets out to deceive. Surrogacy arrangements are not legally enforceable. There have been several cases where mothers who have agreed to act as surrogates in good faith have reneged on the deal, but there has been no question of prosecution.**

**Surrogacy in Britain is governed by the Surrogacy Arrangements Act 1985, which criminalises commercial agencies undertaking surrogacy for money but not the payment of reasonable expenses to surrogate mothers by commissioning couples.** □

# Proposal to stop bad doctors setting up elsewhere

Tony Sheldon, *Utrecht*

Proposals to protect patients against doctors who move to another country in the European Union after being found guilty of professional misconduct have been launched at an Amsterdam symposium this week. They include setting up a computerised European databank with details on qualifications and disciplinary matters that would be mandatory for any host country to check.

As part of its six month presidency of the EU the Netherlands is seeking to strengthen EU directive 93/16 EEC, which regulates the free movement of doctors within the 15 member states. The directive is meant to provide for mutual exchange of information, such as character and professional references and details of serious professional misconduct or criminal convictions related to medical practice.

But a study for the Dutch government by Henriette Roscam Abbing, a professor of health law, concludes that the current measures are inadequate: "There are grounds for believing the present situation does not reasonably justify the trust of the patient." It highlights the case of a Dutch doctor suspended for life in the Netherlands who set up practice in Spain. In Luxembourg a migrant doctor was authorised to practise as the authorities were unaware of proceedings in his original country that led to his suspension.

The Amsterdam symposium Quality of Medical Practice and Professional Misconduct in the European Union, attended by representatives of all EU countries, discussed proposals that the Dutch will now put before the Council of Health Ministers in Luxembourg in June. The health minister, Els Borst-Eilers, told the symposium that patients should not be the "victim of professional misconduct" for want of a "well functioning information procedure." The director general of the Dutch Ministry of Health, Harm Schneider, feared that the Dutch examples were the "tip of the iceberg." He said that it should not be tolerated that a doctor barred in one country could set up in another. Cillian Twomey of the Irish Medical Association said that both a "register of bad apples" and a "statement of good medical practice" were needed.

Concerns were raised, however, that attempts to harmonise definitions of malpractice and good quality across the EU were impossible. A databank was also viewed as tending towards a "big brother" approach. □

*Quality of Medical Practice and Professional Misconduct in the European Union* is available from Professor H Roscam Abbing, Ministry of Health, Welfare and Sport, Netherlands.

# Review proposes more emergency care in the community

Linda Beecham, *BMJ*

The British public should be encouraged to take greater responsibility for dealing with emergencies but should know where and to whom to turn when professional help is needed, according to a Department of Health consultation document.

At the beginning of 1996 the health secretary, Stephen Dorrell, said that there was concern that the existing system of emergency care was too focused on 999 calls, GPs, and accident and emergency departments. As a result a review group, chaired by the chief medical officer, Sir Kenneth Calman, was set up.

The resulting consultation document, *Developing Emergency Services in the Community*, concluded that the provision of emergency care should be coordinated, planned, and managed so that appropriate help was available to people 24 hours a day; that a telephone helpline service should be piloted to advise people where they could get help in addition to the 999 service; and that there should be further research into the viability of alternative models of access to emergency care.

The BMA's General Medical Services Committee says that many of the proposals do not address the need for more resources and fears that much of the burden will fall on primary care. There were only four GPs on the 56 strong review group and there was insufficient involvement of front line nursing and medical staff in the community. They were also worried that the proposed telephone helpline could increase patient demand.

The consultation period ends on 28 February. The review group will reconvene and submit a final report to Mr Dorrell in the spring. □

SIMON FRASER/SCIENCE PHOTO LIBRARY

**GPs are worried that they will bear the burden of emergency care**

*Developing Emergency Services in the Community* is available from the Health Literature Line (tel 0800 555 777).

# Communication overcomes junior doctors' concerns

Jacqui Wise, *BMJ*

**British junior doctors concerns about new working patterns introduced as a result of the new deal can be overcome by good communication, says a report by the Health Services Management Centre.**

**The new deal on junior doctors' hours was introduced on 1 January 1995 to ensure that no doctor works more than an average of 56 hours per week, with a ceiling of 72 contracted hours per week for the least intensive clinical areas.**

**The project, funded jointly by the NHS Equal Opportunities Unit and the Walsgrave Hospitals NHS Trust, found that junior doctors were particularly concerned about the increased intensity of work when on duty despite less hours at work. They were also worried that their weekends would be disrupted more often and that shift patterns would mean that they could not attend post-take ward rounds after a night on call. The researchers also found a high use of locum agencies, high rates of absence due to sickness, and difficulties in recruiting doctors to junior posts.**

**As a result, the medical directorate made changes such as amending the shift patterns and ward round times so that junior doctors could attend post-take ward rounds. The working conditions of the doctors were also improved in several ways. The directorate also successfully bid for three additional senior house officers from the regional task force.**

**The report, *Taking the Temperature of the New Deal*, shows that as a result of the changes junior doctors felt more satisfied with training, and attendance at formal training sessions increased. Fewer locums were needed, sickness absence went down and recruitment improved.**

**Robert Cay, general manager of the medical directorate said: "Twenty months ago nobody wanted to stay here—it was perceived as a dumping ground. The key to change was establishing communication and trust."** □

# Genetics "shop" to open in Manchester airport

Tessa Richards, *BMJ*

The Gene Shop, an innovative venture to increase public knowledge of genetics and genetic screening, will open in Manchester airport on 25 February.

The new shop is a non-commercial venture set up by the genetics department of the Royal Manchester Children's Hospital Trust and Euroscreen, a research programme funded by the European Union.

The Gene Shop will be staffed by health visitors and community paediatricians attached to the Manchester clinical genetics unit, who will be working with a lead health visitor with a background in education and genetics. All have been trained to deal with what is anticipated to be a broad range of inquiries.

"There is a desire among the general public, which is not being met, for more knowledge about the importance of genetic disease and the possibilities and implications of genetic screening," said Dr Maurice Super, who runs the regional genetic unit in Manchester.

"We hope the shop will help define, albeit in a select group, who is seeking information and what their information needs are," he said. "It should provide us with a good range of views because apart from air travellers there are 16 000 people who work on the site and it is a popular venue for a day out from Manchester."

Although it will essentially be an educational resource, the shop will have a quiet area where people can discuss personal matters with the staff. However those who need detailed information and counselling will be advised to contact their GP.

Information about regional genetic services in the UK and elsewhere in Europe will be provided, as well as general educational material in the form of posters and leaflets. In addition, the shop will contain information from the specialist genetic associations support groups such as the Cystic Fibrosis Trust and Down's Association. It will have several interactive touch screen computers, including one suitable for children, and there will be a separate area where videos will be shown.

The effect of this European initiative will be evaluated by the centre for professional ethics of the University of Central Lancashire, headed by Professor Ruth Chadwick, who is coordinating the Euroscreen programme. Professor Chadwick said: "We will not only be auditing who uses it and why, but we will also be interviewing a sample of the users before and after they go into the shop to assess the impact of the information they have received."

While agreeing that it is a good idea to raise public awareness of genetics and encourage debate, Professor Theresa Marteau, the head of the psychology and genetic research department at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals, London, has reservations about the shop. "I think it is very difficult to provide non-directive education about genetics and genetic screening, and I am doubtful whether the evaluation will tell us whether this sort of initiative represents a good use of scant resources.

"Furthermore, I am not convinced of the usefulness of providing all this information. At the moment many of the advances in our understanding of genetics offer little more to the public than a host of uncertainties," she said. □

## *Focus: Washington*

# US medicine marches slowly toward UK solution

John Roberts

Medical systems in the United States and United Kingdom are increasingly mirroring one another—that is, they look alike but in opposite ways. In the UK medicine is a public endeavour that more and more uses private sector schemes. In the US it is a private endeavor that increasingly is being shaped by public policy.

At the top of the US medical agenda this year is Medicare (public insurance for all the elderly) and Medicaid (public insurance for the poorest, especially children). Both programmes are growing much faster than inflation, and Medicare is expected to be broke by 2001.

As a result, patients in both programmes are being pushed strongly toward managed care programmes, in which the government pays insurance companies to contract with doctors to provide the care. In most cases the contracts result in capitation, where doctors (in reality, large groups of doctors) take on the risk of providing all the medical care that is needed.

Managed care looks strangely like fundholding, except that doctors take on all the risks, and the contracts usually include specialists as well, though primary care doctors remain at the helm. The main difference is that in the US an insurance company acts as middleman.

About 12% of elderly Americans—5 million—are in Medicare managed care programmes. Costs are growing at about 7.8% annually, in contrast to earlier years, when they were growing at over 10% a year. This new trend is likely to make congress and the president continue to push elderly Americans into some kind of privately run, publicly funded managed care plan by the end of the century.

Similarly, congress is likely to support President Bill Clinton in giving the states more freedom to force the poor into Medicaid managed care programmes. For example, with congress's and Mr Clinton's blessings, Maryland is moving virtually every poor person into some type of managed care scheme.

Even so, there is a paradoxical skepticism over unbridled private sector growth. Over the past year congress and many state legislatures have told managed care organisations that they cannot overly restrict doctors' decisions or fire doctors who tell patients that better care might be found outside their particular programme. More restrictions are coming this year.

For example, some insurers are telling surgeons that women admitted for mastectomies must be out of hospital within 36-48 hours after surgery (11 January, p 92). The New York State legislature has already moved through a bill that would allow patients and doctors to decide how long a stay is appropriate, and the insurer will have to factor in those costs in future contracts with doctors.

Similar bills will come before congress this year, and most are expected to pass. These "length of stay" bills are fairly safe ways to ingratiate politicians with constituents without alienating most of the business groups.

Some consumer and physicians groups support these government mandated length of stay rules, but others worry that a government that micromanages medical care is no better than an insurance company that does it.

In any case 1997 will show that even under a Republican congress and a fiscally conservative president, America continues to embrace private sector medical care guided with the heavy hand of government, while the UK seems to continue to embrace public sector medical care modulated by the invisible hand of the market. □