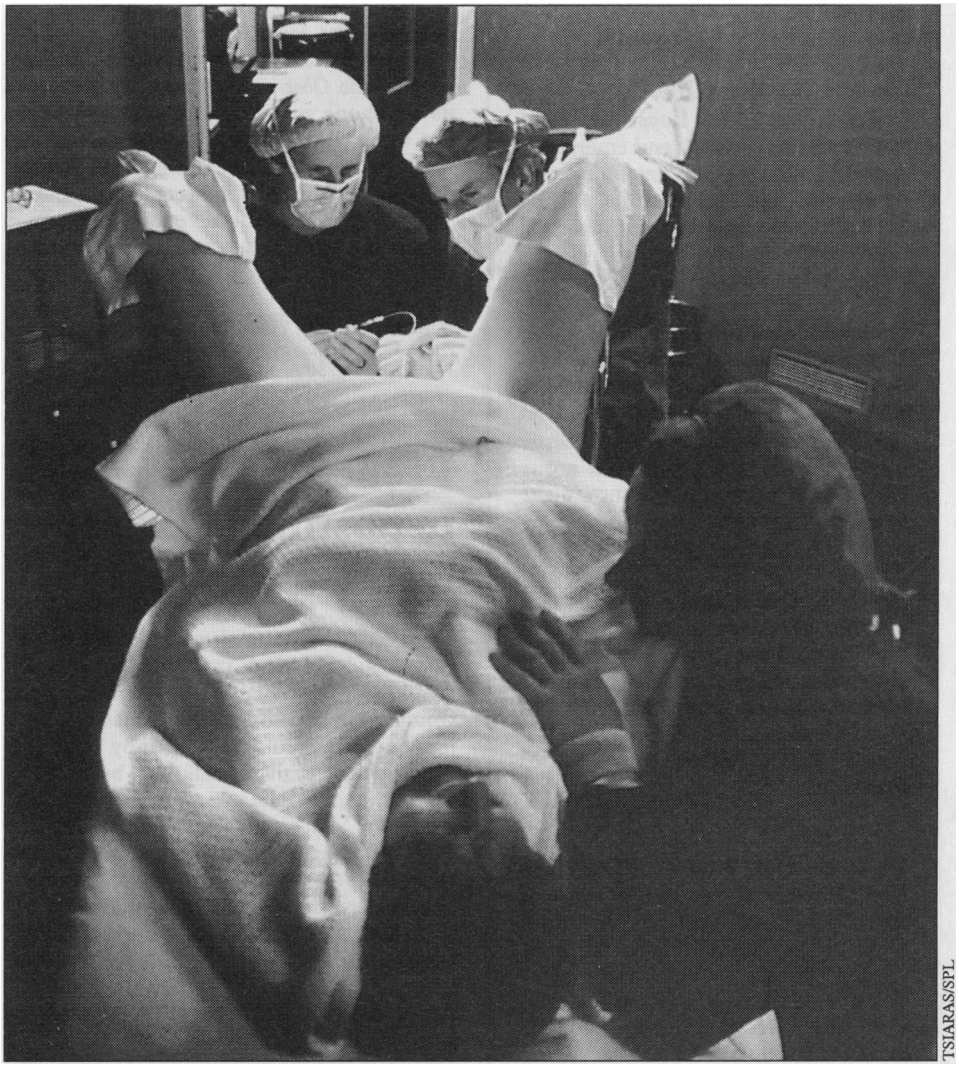
British public will rule on fertility advances



Fertility advances: the debate will not be limited to patients and doctors

Members of the Human Fertilisation and Embryology Authority (HFEA), which licenses fertility clinics in Britain, admitted last week to feelings of unease and distaste at the idea of eggs from aborted fetuses being used to treat infertile women. They said that the public would have the largest say in whether such treatments went ahead.

Professor Sir Colin Campbell, chairman of the authority, said that such scientific advances were everyone's concern and that the authority was trying to establish guidelines for treatments that were only two or three years away. By that time eggs and ovarian tissues from both aborted fetuses and cadavers could be used to treat infertile women.

Professor Campbell's remarks were made at the launch of the authority's 12 page consultation document that sets out the pros and cons of potential advances in infertility treatments and calls for comments over the next five months. The HFEA brought the publication of its report forward after the media reported that a 59 year old British woman had given birth to twins after receiving infertility treatment in Italy and that a black woman had been donated the eggs of a white woman. This document, however, looks only at the potential uses of immature oocytes and ovarian tissue rather than specific inclusion or exclusion criteria for treatment.

The document says that researchers in South Korea have already produced live births from using ovarian tissue from cadavers. The successful transfer of ovarian tissue from mouse fetuses into recipient mice was accomplished 50 years ago and resulted in live offspring. This has not yet been attempted with ovarian tissue from aborted human fetuses. "It is not yet known whether the early female eggs from such material could develop into mature eggs or be capable of giving rise to a baby after fertilisation," says the document.

The grafting of functional ovarian tissue has been carried out for nearly 100 years in mice, sheep, and guinea pigs—all of which have produced offspring.

Existing guidance from the Department of Health (the Polkinghorne report) covers the current use of fetuses and fetal tissue in research and treatment. It does not specifically cover the use of ovarian tissue, and the HFEA says that the guidelines will have to be amended to take account of future developments.

The Polkinghorne report says that the consent of the woman should be obtained for the use of tissue from an aborted fetus for research or treatment—even though this is not required by law. But it states that the consent should be separate from the decision on abortion and should be general—the woman should not know how the tissue would be used. Such precautions were laid down to avoid women being pressurised into seeking abortions to provide tissue for particular purposes. These precautions could be incompatible with the HFEA's code of practice, which states that specific consent must be given by a person providing eggs for the treatment of others.

It would be up to parents to decide if they wanted to donate the ovarian tissue of their dead daughter—an issue that is likely to be more emotive than donating other organs. "A donor's parents might consent in the hope that, although they have lost a daughter, they might gain access to a genetic grandchild," warns the report.

The issue of consent to the use of fetal ovarian tissue is most complex of all. The document says that there is an argument for seeking the consent of the father as his genetic material would also be transferred to future generations. It is clear that "the use of fetal ovarian tissue to alleviate infertility should be considered to be a special case in which the specific consent of the woman undergoing the abortion should be obtained."

The document also asks what the psychological consequences are likely to be for the child who is born from cadaveric or fetal tissue. "The particular implications of finding out that their genetic mother had died before they were conceived, or was an aborted fetus, are unknown."

There are also concerns that ovarian tissues or eggs from an aborted fetus have not

Headlines

Over 10 000 NHS beds closed in 1993: The UK Department of Health has reported that over 10 600 beds in NHS hospitals and trusts were closed in 1993. Since 1981 the number of beds has fallen by more than 120 000, a decrease of 34%.

Casualty patients wait overnight for a bed: A survey by the Royal College of Nursing of 76 accident and emergency departments in Britain has found that nearly half had had patients waiting overnight for admission and nearly a third did so regularly.

US health care will cost over £707bn: The US commerce department says that health care costs will rise by 12·5% next year and will cost $1·06 trillion (£707bn) or 15% of the gross domestic product. Nine of the 20 fastest growing manufacturers in the US now make health related products.

Nearly all Dutch babies are planned: Because of increased use of contraceptives and the availability of legal abortion only 2% of pregnancies in the Netherlands are unplanned, says the Dutch Institute for Social Sex Research. This compares with 28% 20 years ago.

US states must fund abortions: The United States White House has told states that they must use Medicaid funds to pay for abortions for poor women who are the victims of rape or incest even though there are several state laws forbidding this use of funds for abortions unless the woman's life is in danger. Federal officials said that federal law must take precedence.

US lifts ban on fetal tissue research: The US government has ended the six year ban on research on fetal tissue by awarding $4·5m (£3m) for the implantation of fetal tissue in up to 40 patients with Parkinson's disease.

Nearly half of Chinese male doctors smoke: A symposium on smoking and health in Beijing last month heard that 46% of male doctors in China are daily smokers. A quarter started smoking while at medical school. There are 300 million smokers in China, which is responsible for a third of the world's tobacco consumption. It is predicted that 50 million Chinese people under 20 will die prematurely from smoking.

been put under the pressures that govern survival. "This raises questions about the degree of risk of abnormality in embryos produced using such tissue. This might be seen as breaking a natural law of biology."

The 21 members of the HFEA, which plans to announce guidelines in the autumn, include the actress Penelope Keith, a senior official from the Bank of England, and the managing director of BBC radio as well as professors of genetics, child psychiatry, family studies, law, and obstetrics.

While the HFEA waits to hear the public's opinion the *Observer* published the results of its telephone survey of just over 500 adults last week. Altogether 57% said that it was not right to use eggs from aborted fetuses, compared with 35% who were in favour.

The BMA's medical ethics committee hopes to make its own recommendations next month.—LUISA DILLNER, *BMJ*

Donated Ovarian Tissue in Embryo Research and Assisted Conception is available free from HFEA, Paxton House, 30 Artillery Lane, London E1 7LS.

French react strongly to postmenopausal births

The French health minister, Philippe Douste-Blazy, said last week that fertility treatment should not be available for postmenopausal women. He said that such pregnancies were immoral and should be banned by law. "It is totally shocking that a child can be 18 when his mother is 80," he said.

Simone Veil, minister of social affairs, said that "very rigorous rules" limiting fertility treatment to women who were premenopausal were already part of the bioethics bill that has already been examined once by parliament.

CHESNOT/SIPA/REX FEATURES

Simone Veil says that rigorous rules on fertility treatments are already before parliament

The bioethics bill, which has taken nearly four years to prepare, states that fertility treatment should be limited to heterosexual couples of childbearing age who are sterile. It is not yet law.

Elizabeth Badinter, a leading French feminist, said that the proposed ban was an assault on women's freedom of choice. She said that a postmenopausal woman could be a better mother than a young woman who was either a drug misuser or psychologically disturbed.

Professor Jean-Francois Mattel, a consultant on ethics for the government, said that the birth of twins to a 59 year old British woman after treatment at an Italian clinic was "a corruption of medicine, contrary to nature.... The woman is reduced to the role of an incubator."

Several commentators have said that for legislation to be effective it must be adopted by all the countries of the European Union to prevent women from travelling between countries to obtain treatment.

The French parliament is now expected to meet in an extraordinary session this month to re-examine the whole bioethics legislation. The bill was accepted by parliament in 1992 but has since been amended by the senate so many times that it now reads like a new set of proposals. Parliament will pass the bill back to the senate in time for its spring session.—ALEXANDER DOROZYNSKI, medical journalist, Paris

Canada could ban some reproductive technologies

A Canadian royal commission has recommended that several aspects of new reproductive technology should be outlawed and that others should be federally regulated and licensed.

Four years of research, public hearings, and surveys involving more than 40 000 people—including 300 researchers—led the Royal Commission on New Reproductive Technologies to propose bans on four main activities. These are the use of embryos in research related to cloning and animal-human hybrids; the fertilisation of eggs from female fetuses for implantation; the sale of eggs, sperm, zygotes, and fetal tissues; and advertising for, paying for, or acting as an intermediary for preconceptional (surrogacy) arrangements.

The chairperson of the commission, Vancouver geneticist Patricia Baird, said that Canada must not repeat the mistakes of the US, where market forces are driving an industry of human reproduction. She said that billboards there hawk "wombs for rent," infertile couples can buy sperm from Nobel laureates, and prospective parents can pick from a catalogue the characteristics that they want their babies to have.

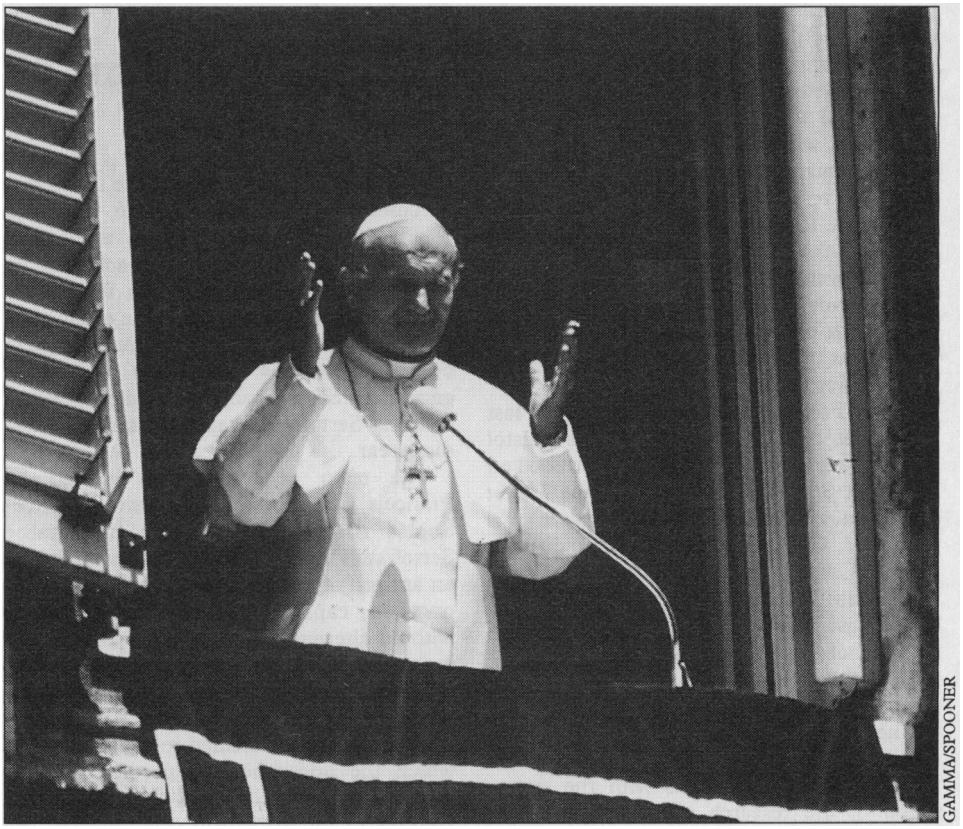
The commission's report found a variety of practices in Canada. Some, "such as donor insemination using sperm from donors who have not been tested for HIV," it found

to be dangerous. Some could be harmful to children born through the use of technologies without proper records being kept on their origins. And some did not respect women's choices because, for example, their chances of being referred for prenatal testing varied more than fourfold across the country.

"We found insufficient emphasis on the prevention of infertility," said the report. "We found some discriminatory practices in access to services, some clinics preparing to carry out procedures to allow surrogacy, and some commercial clinics existing to treat sperm to allow sex selection. Procedures are being offered as treatments without good evidence that they are effective, when they should be offered only in research trials."

The commission says that the federal government must act as the guardian of the public interest and should set up a national reproductive technologies commission and a compulsory licensing system for services that provide the technologies. Members of the new commission should represent a broad range of experience including reproductive medicine, ethics, law, and social sciences. At least half of the members should be women, and the commission should include members with disabilities, those who are infertile, and members of racial minorities.

The Society of Obstetricians and Gynecologists of Canada said that "in time of economic restraint, we believe the practical implementation of the commission's recommendations should be weighed over and against the benefits for Canadians. . . . We want bureaucracy that helps, not hinders access to reproductive health care. We are very concerned that this might be the consequence of the report."—DAVID SPURGEON, scientific and medical journalist, Quebec



GAMMA/SPOONER

The Pope: only metres away from Professor Antinori's fertility clinic

Italy vows to control fertility treatments

The case of Professor Severino Antinori, an Italian doctor who provided in vitro fertilisation treatment for a 59 year old British woman, has generated moves for tighter regulation of fertility treatment in Italy. The National Bioethics Committee said last week that it will publish guidelines on in vitro fertilisation at the end of the month.

A Christian Democrat, Romano Forleo, has meanwhile tabled a private member's bill to limit the age at which women can be treated. "It's a serious matter that an aging English woman can obtain in Italy what her own country refused on ethical grounds," said Senator Forleo.

A spokesperson for the National Bioethics Committee, which includes some 40 doctors, professors, gynaecologists, and psychologists, this week accused Italian doctors of "losing sight of the moral and ethical implications of their work." "We have to consider what's best for children born to elderly mothers. People always talk of the mother's needs, rarely those of the child," said Professor Adriano Ossicini, president of the committee.

The committee's long awaited guidelines will provide parliament with the basis to regulate fertility treatment in Italy. "There is no law, even though practically every political party has proposed one," said Luigi La Ratta, president of the National Association for Demographic Control.

The lack of legislation reflects the lobbying power of the fertility clinics. There are some 300 private fertility clinics charging up to 40 million lira (£16 000 or $24 000) for treatment. More worryingly, the absence of legislation has encouraged the growth of clandestine clinics. Just 20 of the country's 80 sperm banks are now linked to Cecos, the official centre for the collection and study of eggs and sperm.

Professor Antinori has already been ostracised by the Italian medical community for his development of controversial infertility treatments. At his private clinic in Rome he claims to have treated over 1000 women, with 35 women aged over 50 having given birth. In the wake of the British controversy Professor Antinori further fuelled the Italian debate by announcing that he was treating a 63 year old farmer's wife from Viterbo. The woman, Rosanna Dellacorte, is three months pregnant and could become the oldest mother on record.

Some of the fiercest opposition to the professor's work has come from the Catholic church. The Vatican's newspaper, *Osservatore Roman*, denounced an operation performed by Professor Antinori in 1988 as killing off "the dignity of a woman."

Professor Antinori's clinic in Rome is situated several hundred metres from the Pope's residence in St Peter's Square.—CHRIS ENDEAN, Rome correspondent, *European*

Charity Commission censures British cancer charities

The Charity Commission, the government organisation that oversees all British charities, last week censured the Imperial Cancer Research Fund (ICRF) and the Cancer Research Campaign (CRC) for inadequacies in their mechanisms for supervising and evaluating research. The commission plans to consult the medical reseach community and draw up guidance on good practice for the funding of medical research by charities.

The commission began its investigation into the two charities, which between them have an annual income of £100m ($150m), after the publication of research that they had funded into the effectiveness of the complementary treatments offered by the Bristol Cancer Help Centre. The research, which was published in the *Lancet* in September 1990, showed that patients with breast cancer who attended the centre did worse than control patients who did not. The patients had not been randomised, and Sir Walter Bodmer, director of research at the ICRF, wrote to the *Lancet* after the initial publication to say, "Our own evaluation is that the study's results can be explained by the fact that women going to Bristol had more severe disease than control women."

After publication of the study the number of patients attending the Bristol centre fell dramatically and the centre nearly went into receivership. One of the study's authors, Professor Tim McElwain from London Uni-

versity, killed himself two months after the study was published.

Pat Pilkington, one of the cofounders of the Bristol Cancer Help Centre, said that people at the centre were "absolutely delighted" with the Charity Commission's report. "Imagine," she said, "how devastating the results of the original study must have been for a vulnerable patient sitting watching the nine o'clock news." Many patients were horrified and angry, and a Bristol Study Support Group was founded in London. It compiled a large dossier on the study and presented this to the Charity Commission.

Robin Fox, editor of the *Lancet*, said last week that after he dies the words Bristol Cancer Help Centre will be found tattooed on his heart. Statistical refereeing at the *Lancet* has been enhanced since the paper was published. Gordon McVie, scientific director of the Cancer Research Campaign, said: "Our view is that the researchers made an honest scientific mistake during their analysis of their findings. But it was bad manners that participants in the trial weren't given the results before publication.

The Charity Commission investigated all aspects of the funding of the research and found particular problems with the supervision of the research after the grant was given. The CRC did set out the terms and conditions of the funding in a written document, but it "did not adequately set out the respective responsibilities of the supervision of the research by the funding charities, the researchers and the institute employing the researchers." The ICRF, which rarely gives grants to outside researchers, had no written terms and conditions of funding. "No one," the commission found, "adequately supervised the Bristol study to ensure the proper application of charitable funds... the CRC and the ICRF could not ensure that the charitable funds were properly applied."

The commission says that in this case the cancer charities did not ensure before publication that the research had been properly carried out. "We cannot," said Dr McVie, "review all 1000 or so studies produced by us each year before publication, and we wouldn't want to. We don't want cancer charities censoring research when they don't like the results." Hugh Rogers, a spokesman for the Charity Commission, said that the commission had no intention of interfering with academic freedom: "Academic freedom is important but so is the proper disbursement of charitable funds."

The commission found no problems with how the charities conducted themselves before giving the grants but said that "the practices and procedures adopted generally in the field of medical research may be insufficient to allow charity trustees who award funding for medical research to be undertaken by third parties to discharge properly their duties, as trustees." Some medical charities are upset that the commission reached this conclusion after examination of only one unusual case. Mr Rogers said that he thought that the commission had enough evidence to begin a general discussion on the supervision by charities of the research they fund.—RICHARD SMITH, *BMJ*

Scientists grow sperm from germ cells

For the first time researchers have succeeded in culturing male germ cells in vitro and bringing them through meiosis to become mature sperm. The trick was achieved by culturing immature germ cells from mice with Sertoli cells. Sertoli cells are essential to support and nourish the immature germ cells, but previous attempts at coculturing germ and Sertoli cells have failed because cultured Sertoli cells rapidly degenerate and disappear.

The team of researchers, headed by François Cuzin of the Université de Nice-Sophia Antipolis, decided to immortalise Sertoli cells by introducing into their genomes an antigen of polyomavirus, which acts as an oncogen capable of immortalising cells without altering their properties. Once a cell is immortalised it can continue forever in tissue culture from one cell generation to the next.

The researchers created a line of mice in which the oncogene is expressed in both germ and Sertoli cells. They then established cultures of mouse Sertoli cells carrying the oncogene and cocultured them with germinal cells of 8 day old, immature mice. The germ cells matured successfully and 10 to 12 days later gave rise to mature haploid sex cells.

The poorly understood phenomenon of meiosis can now be studied in vitro, and this may lead to the identification of genes and proteins involved in dividing DNA into two. A practical aspect of such research will be the study of substances that are toxic to germ cells. Such studies may also lead to the identification of some of the reasons for male infertility but could raise ethical questions: if human germ cells can be brought to maturity in vitro, will it be possible to introduce selected genes into them? But Professor Cuzin says that he does not know whether human germ cells can be cultured in the same way because their development may not be helped by immortalised Sertoli cells from mice. It may not be possible to create an immortalised line of human Sertoli cells.

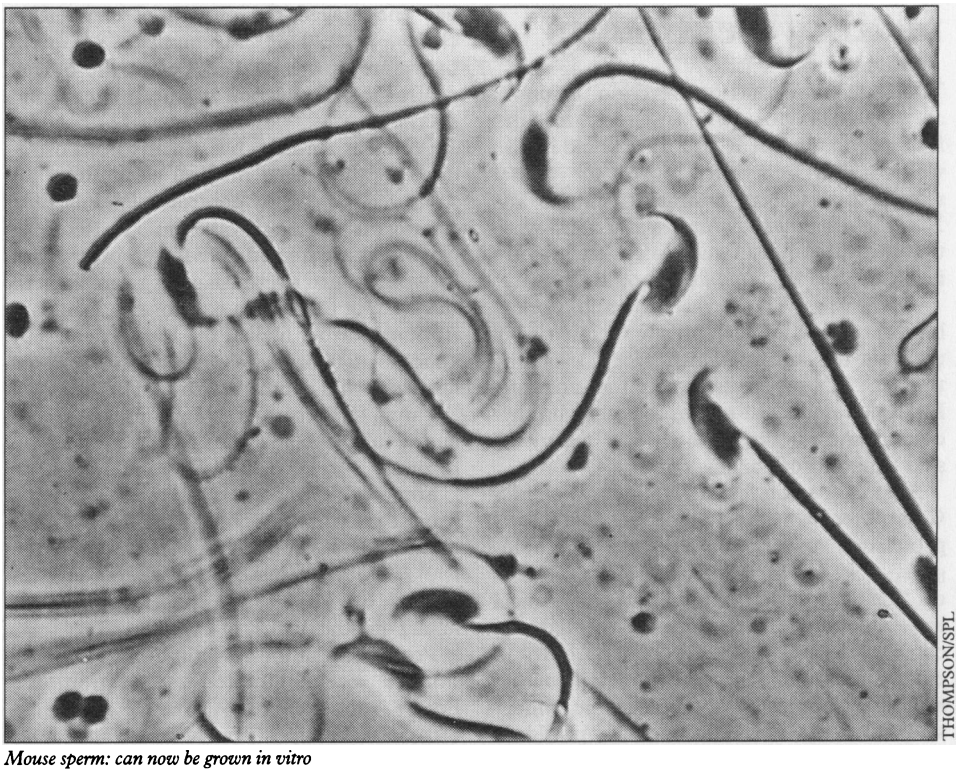
The work was carried out in collaboration with the Medical Research Council Human Genetics Unit of Edinburgh and the Sloan-Kettering Institute in New York. It was published last month in *Cell* (1993;75: 997-1006) with the title "Transmeiotic differentiation of male germ cells in culture."—ALEXANDER DOROZYNSKI, medical journalist, Paris

Maternal deaths from haemorrhage double in UK

Maternal deaths due to haemorrhage have doubled in the United Kingdom since the last report from the Confidential Enquiry into Maternal Deaths, which covered 1985-7. The inquiry's latest report, covering 1988-90, also shows that deaths from sepsis have nearly doubled.

"Many of the overall favourable trends seen in previous reports have not been maintained," says the report, published by the government. "There is a need for critical reappraisal of the administration and delivery of maternity care."

The assessors for the inquiry—one in obstetrics, anaesthetics, and pathology from



THOMPSON/SPL

Mouse sperm: can now be grown in vitro

each health region—found evidence of substandard care in almost half of all the cases of maternal death. The report draws attention to the "significant number of cases where major problems were handled by junior doctors, a recurring theme of recent reports."

The inquiry found that 238 women died during pregnancy or before 42 days post partum during 1988-90. This compares with 223 in the previous triennium. "Given the increase in the number of maternities over the period, the mortality rate has not changed between the two triennia," says the report. The rate of maternal death remains 10 per 100 000 maternities. This is half the rate in 1973-5, but no fall has been reported in the past three reports.

The most common causes of maternal death are thrombosis and thromboembolism, hypertensive disorders of pregnancy, haemorrhage, and ectopic pregnancy, which account for over 60% of direct maternal deaths. A direct maternal death is defined as one that results from obstetric complications of pregnancy, labour, and the puerperium.

In the 27 deaths due to hypertensive disorders of pregnancy, care was judged to be substandard in nearly 90% of cases. "Underlying factors were delay in taking clinical decisions, inadequate control of blood pressure and failure to appreciate, often at too junior a level of clinical responsibility, the seriousness of symptoms and signs," says the report. "In many cases postpartum care was clearly substandard... the lack of improvement is both disappointing and perplexing."

One pregnant woman with a diastolic blood pressure ranging between 100 mm Hg and 130 mm Hg waited 22 hours before seeing a consultant. Her blood pressure was not monitored adequately overnight because staff were worried that her sleep would be disturbed. The next morning she was unconscious, and she died shortly afterwards. Necropsy showed that she had hypertensive encephalopathy. "Obstetrics units must impress upon all staff from the first day of appointment, the treacherous nature... of the hypertensive disorders of pregnancy," says the report.

Care was also considered to be substandard in over half of the 22 cases of death directly due to antepartum and postpartum haemorrhage. Five deaths were due to placenta previa—four of the women who died had elective caesarean sections done by obstetric registrars.

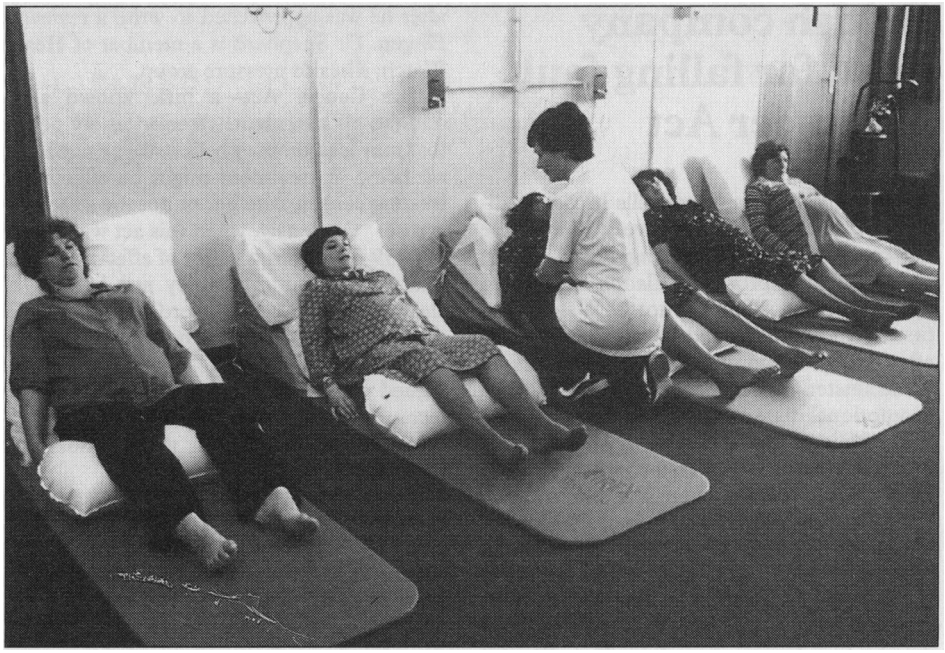
Previous reports have said that a consultant should be present at these operations as placenta previa can cause uncontrollable haemorrhage at delivery. "It is disappointing that after the 1985-7 triennium, during which no deaths associated with placenta previa occurred, this advice now seems in danger of being forgotten," says the report. The inquiry recommends that obstetric units should have written protocols for the management of massive haemorrhage.

The report also recommends that all doctors should react promptly to women of reproductive age who present with lower abdominal pain. "The most important contribution to reducing the risk of death from ectopic pregnancy is an awareness by medical attendants," says the report. A total of 19 women died of ectopic pregnancies; care was substandard in seven. This is more than double the rate of such deaths reported in the 1982-4 triennium.

Four women died directly from being anaesthetised—compared with 27 during 1973-5. But 60 women died directly after caesarean section, compared with 50 in the previous triennium. In one in three cases care was substandard. "Many deaths, particularly from haemorrhage, were associated with inappropriate delegation of high risk cases, inadequate consultation and lack of adequate support facilities," says the report.

The report urges that infection must never be underestimated as a cause of maternal mortality—17 women died of sepsis of the genital tract in this triennium, compared with seven in the previous one.—LUISA DILLNER, *BMJ*

Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1988-1990 is available from HMSO bookshops, price £12.50.



Pregnant women: most will stay healthy but things can go wrong

Consultants face compulsory education

Consultant obstetricians and gynaecologists in Britain will have to continue their medical education, said the Royal College of Obstetricians and Gynaecologists last week. This will be the first time that continuing medical education has been made compulsory in Britain.

From this month each consultant member of the college will have to enter a programme of continuing medical education and register a minimum of 200 credits over five years. These will be earned from a range of educational activities, including college based, hospital based, and personally arranged activities. One hour of an applied activity is equal to one credit. At the end of the first five year cycle the college will publish a list of trained specialists, which will be available to the public.

Doctors whose names do not appear on the list will not be considered for merit awards or be eligible to serve on college committees. They will be barred from examining or acting in any official capacity on behalf of the college. A leaflet on the programme, produced by the college, warns: "Legal and professional conduct defence of a member may rest in part on the ability of the individual to demonstrate commitment to continuing medical education through appearance of their name on the roll."

The Royal Australian College of Obstetricians and Gynaecologists already runs a similar programme, which requires consultant members to gain sufficient points for continuous certification. Doctors who fail to get the points lose certain rights to charge specialist fees.

In Britain all members of the royal college who are in clinical practice must take part in the programme. This includes consultant members working only in private practice, those partially retired, and those doing medicolegal work. Members will not have to pay any extra fees.

Professor David Purdie, a member of the committee on continuing medical education, said that continuing medical education was not a legal requirement in Britain. Professor Robert Atlay, chairman of the committee, said: "We are not in a position to stop people practising or strike them off."

Other colleges are likely to follow suit. Dr Peter Toghill of the Royal College of Physicians said that the working party for continuing education of the three royal medical colleges would publish its report on continuing medical education in the spring and that participation in a formal system would become obligatory.—RAJENDRA KALE, *BMJ*

British company fined for falling foul of Cancer Act

A company in Britain that sells herbal medicines was convicted last week under the Cancer Act 1939 of making illegal claims about one of its products. Eladon Ltd, which operates from Bangor, north Wales, was fined £500 and ordered to pay £3500 costs after being found guilty by magistrates in Whitminster of contravening the act in its promotional material.

Eladon's product, Elagen, is an extract of Siberian eleutherococcus, a root widely used by doctors in Russia, where it is credited with curing a wide range of ailments. The claims about its efficacy were sent to potential customers who had first made inquiries to the company. Eladon was reported to Gloucestershire County Council's trading standards department by Dr Charles Shepherd of Stroud, Gloucestershire, a medical adviser to the ME Association (for patients with myalgic encephalomyelitis) after he was approached to write a review of Elagen. Dr Shepherd is a member of Health Watch, a health pressure group.

The Cancer Act—a little known act—outlaws all statements directed at lay people that may lead them to believe that a particular medicine or treatment might be effective in treating cancer, whether or not the statement is true. "Obviously, when this act was passed in 1939 there weren't a lot of effective cancer treatments around, so they just banned all claims," said Dr Shepherd. "Perhaps the wording of the act should now be looked at to prevent abuse of this law." Eladon had argued in its defence that even a doctor recommending radiotherapy or chemotherapy was technically guilty under the Cancer Act.

In one leaflet, printed in 1991, Eladon told customers that Elagen would soon be available on NHS prescription once it had been passed by the Advisory Committee on Borderline Substances. In fact the drug was never passed by the committee, and in 1992 it was placed on the list of drugs that are not prescribed on the NHS.

A newsletter sent out in 1992 to previous customers quoted a Dr Kupin of the Cancer Research Centre in Moscow. His research was said to indicate that eleutherococcus helped the immune system to cope with chemotherapy and was therefore a useful adjunct to conventional cancer treatment. The prosecution did not challenge this research. The mention of cancer in an advertisement, however, was found to be illegal. Eladon was fined less than the maximum of £1000. This might have been because of the company's limited resources, the absence of complaints from patients with cancer, and the modest nature of the claims.

Dr Moira Williams, a general practitioner who is married to a director of Eladon and has written about eleutherococcus in *General Practitioner*, *Hospital Doctor*, and *Cytology*, said that the company had been taken aback by the prosecution. "We've always been ethical and tried to put forward genuine research. Frankly, I think it's unfair, especially when so many other drug companies are just interested in making a profit no matter what. There have been so many herbal remedies that have been disreputable that we've all been tarred with the same brush."
—OWEN DYER, freelance journalist, London

Focus: Westminster

The shifting politics of tobacco advertising

Britain's ruling Conservative government is battle hardened in opposing a blanket ban on tobacco advertising. For years it has fought against the ban in the capitals of Europe. But until now it has not had to face the same challenge back home in the British parliament as it has in the European Union. Next month, however, the House of Commons will consider the Tobacco Advertising Bill, which seeks to outlaw all tobacco advertising beyond the point of sale. It is the first substantive attempt at a statutory ban in Britain. The chances of the bill becoming law are not high, but it is none the less an important landmark in a rapidly changing scene.

In recent years the balance of argument and numbers in Britain has been shifting inexorably in favour of a state imposed ban. It tipped decisively about three years ago when the Labour party made its support unequivocal. The Commons health committee also came out in support of a Europe wide ban.

As a result there exists a potential majority in parliament to outlaw tobacco advertising. In a vote last year 21 Conservatives were among the 206 MPs who supported a token bill to make tobacco advertising illegal. If it came to a showdown it is quite possible that the government would be obliged to concede defeat rather than risk its 17 seat majority being overturned. But so far no such direct confrontation has arisen.

Now comes the Tobacco Advertising Bill. As a private member's bill it is initiated by a single MP, rather than by the government, but if passed it becomes no less the law of the land than if it had been introduced by the government. The legalisation of abortion and the abolition of hanging were enacted through private member's bills, though both had the singular advantage of a sympathetic government. Nowadays it is difficult for private members' bills to succeed if they are contentious or cut across vested interests. So what chance has the latest bill? Its sponsor, Labour MP Kevin Barron, has all party support and the backing of about 100 organisations, including the BMA and the medical royal colleges. Ranged against him are the libertarian tendency and the tobacco industry.

The bill's only advantage is that it has priority for a second reading debate on 11 February. From then on it is vulnerable to obstruction until it runs out of time. A hostile government need not even put its head over the parapet: government whips can always ensure that some MPs will delay the bill's progress by putting down amendments. So far the government holds fast to its objection to a statutory advertising ban, as the prime minister made clear in a letter to the BMA last month (8 January, p 141).

But while the government is set to oppose the bill, it may in fact be less doctrinaire than it appears. Health ministers say their minds are not closed, though they are not convinced that a statutory ban would achieve better results than their longstanding voluntary agreement with the tobacco industry to constrain advertising. This agreement has removed tobacco advertisements from television, radio, cinemas, teenage magazines, and some shop fronts. The United Kingdom claims a better record of falling tobacco consumption than other European states which have banned advertising. The government is currently spending £12m on an anti-smoking advertising campaign directed at parents, and it is committed to raise tobacco duties by 3% above inflation annually. Its position is that it is prepared to do anything to cut smoking—short of a statutory ban on advertising. For example, voluntary controls may be strengthened.

It is no secret that the government is contemplating the voluntary ban on advertising being extended substantially—to outdoor posters, as well as to all women's magazines and shopfronts. That would leave only newspapers and general magazines as the last bastions, together with sports sponsorship. This talk of extending the voluntary agreement might look like a pre-emptive strike to the promoters of the bill. In fact the extension is the government's response to its own Smee report of 1992, which pointed to a direct relationship between advertising and consumption.

If the extension to the voluntary agreement comes about Britain will have moved towards a de facto ban on tobacco advertising—though the final push will require more pressure of the kind that is now being applied in parliament.—JOHN WARDEN