

Manchester tackles failure rate of Asian students

The University of Manchester Medical School admitted last month that male medical students with Asian surnames are more likely to fail their final clinical examinations than other students. Professor Stephen Tomlinson, dean of the school, said that 10 students out of 230 failed in 1994—all were male and had Asian surnames. These students were found to have failed their clinical but not their written examinations. About a quarter of medical students at Manchester are from ethnic minorities, and most of these are Asian.

"It became clear during the summer of 1994 when these medical students failed that there was a problem," said Professor Tomlinson. "We immediately set up a study to look at the overall performance of people with Anglo-Saxon names compared with people with names from ethnic minority groups. The numbers are small and it's difficult to separate them out, but our conclusion is that most of the students who failed would have been born in this country, although we don't know this for a fact because we have not asked where they were born."

Aneez Esmail, a senior lecturer in general practice at Manchester University who has done research into ethnic minority issues, was a member of the working party set up to study the problem. "We used names as a proxy for ethnicity," he said. "We found a significant statistical association between men with Asian names and failing clinical exams. We did not find the association in written exams. These were not substandard students. They were accepted to Manchester University on the basis of the same A level criteria as everyone else. If anything they are likely to have been above average."

The working party has come up with recommendations that the medical school has agreed to adopt. New students will complete an ethnicity form on entering medical school and this will be used to monitor their performance. "We want to do a prospective study to follow this problem," said Professor Roger Green, dean of medical undergraduate studies at the school.

"We are also introducing more structured exams that use more objective criteria to mark students. They will help to get rid of individual examiner bias. It's easier to identify what the problems are if examiners have to mark the history and examination in a structured way—for example, whether the candidate felt a patient's spleen or not."

The medical school will also monitor the ethnicity of its examiners and put "them



University of Manchester Medical School

through a training course that will deal with sex and ethnic issues. "We haven't diagnosed the problem yet," said Professor Green. "In clinical finals there is a complicated interaction between the patient and student, the student and examiner, and even the patient and the examiner."

In future the medical school will be looking at the ethnicity of patients who volunteer to participate in the clinical finals examinations. "In central Manchester about 10% of the population is Afro-Caribbean and 10% is Asian—we will be looking at the proportions that volunteer to take part in clinical finals," said Professor Tomlinson.

"I would expect that all my fellow deans could ask the same questions as we have. This can't be a problem unique to Manchester, and it isn't unique to medicine. Whenever there is a one to one situation between an examiner and candidate you need to ask if people from ethnic minorities do less well. This issue goes across the whole of higher education whether it is in art, history, or languages."

Students at Manchester who fail any part of their clinical finals are given one to one teaching and counselling. Professor Tomlinson said that over the past five years only two students who failed finals did not graduate with a medical degree. One had an

Asian name and one had an Anglo-Saxon name.

Manchester's public approach to the problem is applauded by Dr Esmail. "I'm impressed that as soon as the problem became known there was a decision to do something about it. I have a lot of respect for the way that they took this seriously in Manchester."

The University of Leicester Medical School has just over 100 medical students a year and about a quarter are from ethnic minority groups. Professor Frank Harris, dean of the medical school, said that in the past three years no British students with ethnic minority surnames had failed their final examinations.

"We do not ask students to make an ethnic declaration but we do keep an eye on what is going on because this is a very sensitive issue," he said.

"Most students will fail finals on their clinical exams because written exams cannot compensate for clinical competence and the British system is biased towards clinical competence. In our finals students should see two examiners, and if they are going to fail then they should see the external examiner. If any discrimination is going on somewhere it must be something unconscious—there can't be collusion."—LUISA DILLNER, *BMJ*

French antiabortionists march in Paris: Women's rights groups in France fear that a 15 000 strong antiabortion rally in Paris indicates increased opposition to abortion after 20 years of legalised abortion. Activists have staged sit ins at clinics and chained themselves to operating theatres in attempts to stop abortions being carried out.

Embryology authority will publish league tables: The UK Human Fertilisation and Embryology Authority has announced that it is consulting clinics and patient organisations before it publishes success rates for in vitro fertilisation and donor insemination later this year. Results will be adjusted for differences in patients.

Many French thermal spas are unhealthy: An investigation by the French government into thermal and health spas has shown that spring water is sometimes mixed with city water, health regulations are often ignored, staff are undertrained, and clients are overcharged. About 600 000 people a year attend French spas, most on medical prescription.

US government approves anti-alcohol drug: The United States government has approved the use of naltrexone to treat alcohol dependence. It is the first new anti-alcohol drug for 40 years and has previously been used to treat heroin dependence.

Studies show minorities suffer poor health care: Two new studies of the health and lifestyles of black and ethnic minorities show differences between these groups and the population as a whole. The Health Education Authority's first national survey on behaviour and attitudes, *Black and Minority Ethnic Groups in England*, shows that health messages are not getting through. The King's Fund's *Health, Race and Ethnicity* shows that minority ethnic groups are experiencing poorer quality contact with the health service than the white population.

More than 50 NHS trusts have deficit: A total of 22 NHS trusts in England made losses in 1994, and more than 50 are running a cumulative deficit, according to C4 Consulting, an independent consultancy which studied the annual accounts of the 292 trusts in England in 1994.

Humanitarian aid is not enough, says charity

Strong criticism of the use of a purely humanitarian approach to deal with global crises is contained in a new report from the international medical aid organisation Médecins Sans Frontières. The report, *Populations in Danger 1995*, says that such an approach acts as "a blindfold which allows us to bask permanently in the warmth of our own generosity."

The criticism is made by the organisation's secretary general, Alain Destexhe. He says: "All over the world, there is unprecedented enthusiasm for humanitarian work. It is far from certain that this is always in the victims' best interests."

He says that the "emergency ethic" has rebounded on victims from Bosnia to Rwanda. "In dealing with countries in local wars, humanitarian aid has acquired a near monopoly of morality and international action. It is this monopoly that we seek to denounce. Humanitarian action is noble when coupled with political action and justice. Without them, it is doomed to failure."

The report examines in detail five crises—in Burundi, Rwanda, Zaire, Haiti, and Bosnia. It also looks at famine and malnutrition worldwide and at managing disease. In addition, it features a 40 page humanitarian atlas highlighting the key problems faced by humanitarian organisations today—conflict, refugees, famine, and epidemics.

Médecins Sans Frontières is frequently outspoken. It refers to the relief of outsiders when disease arrived among the hundreds of thousands of Rwandan refugees in Zaire. "The people who had sat stony-faced while innocents were massacred were suddenly deeply moved by the damage wrought by a bacterium. The miraculous and unheralded arrival of dysentery gave the world a born-again virgin purity. Genocide took a back seat to a humanitarian disaster. The drama

of the rescue could now begin."

The organisation also admits to its own call for arms in Rwanda: "It was the extreme nature of this tragedy that obliged Médecins Sans Frontières to take a stand, cast aside its humanitarian neutrality and clamour for military intervention in full knowledge of the risks entailed in 'armed humanitarianism.'"

The problem of land mines, which remain in place long after a war has ended, is also addressed. The report points out that, "in addition to the individual human tragedies they cause, land mines wreak havoc on the fragile health systems of the countries affected."

The world's refugee population poses a huge problem for aid workers, says the report. At the end of the 1980s the total number of refugees worldwide was about 15 million. By 1993 it was 19 million. The "flawless logistics" required for food distribution do not always exist, so that although food aid may be supplied to a country it does not always reach its intended target. Widespread vitamin deficiencies cause further problems, often on an epidemic scale.—CLAUDIA COURT, *BMJ*

Populations in Danger 1995 is available from Central Books, 99 Wallis Road, London E9 5LN, price £9.99.

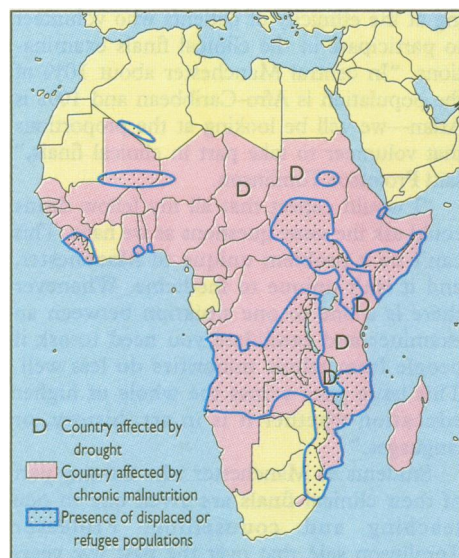
Doctors warn of crisis as commission folds

The New Zealand government has announced that it is to disband the Public Health Commission, which it established just 18 months ago. The commission, which formed one of the key elements of the government's health reforms, is to disappear in the middle of next year. Its functions will be absorbed into the Ministry of Health.

The board of the Public Health Commission, which was responsible for reviewing all the commission's major decisions, has resigned en masse with effect from 31 January. Members of the board are warning of a potential crisis in public health. The chairman of the board, Professor David Skegg, said: "Possible examples would include a major epidemic of a vaccine preventable disease, a serious outbreak of a foodborne illness, or an inadequate response to a civil emergency."

There had been concern that public health money was being directed into treatment services. Professor Skegg said that one reason why the government had established a separate commission was to protect the public health budget. The health minister, Mrs Jenny Shipley, promised that funds for public health would be protected within the ministry.

The move to wind up the Public Health Commission has been condemned by doctors. Dr Dennis Pezaro, chairman of the New Zealand Medical Association, said that public health was in danger of languishing in



Areas of drought, malnutrition, and refugee populations in Africa

the doldrums. Professor Robert Beaglehole, of the department of community health at Auckland's School of Medicine, said that the commission may have been a victim of its own success and come under pressure from the alcohol, food, and tobacco industries for its promotion of healthy living.

But the opposition health spokesperson, Lianne Dalziel, said that had the Public Health Commission taken a stronger stance on issues such as alcohol advertising and antismoking measures it would have found stronger support.—CHARLES ESSEX, community paediatrician, Auckland

Crocodiles help to develop artificial blood

A new genetic brew of human and Nile crocodile blood could improve existing artificial blood products in transmitting oxygen to the tissue, says an article in last week's *Nature*. The new haemoglobin molecule, Hb Scuba, was engineered by researchers at the Medical Research Council's Laboratory of Molecular Biology in Cambridge.

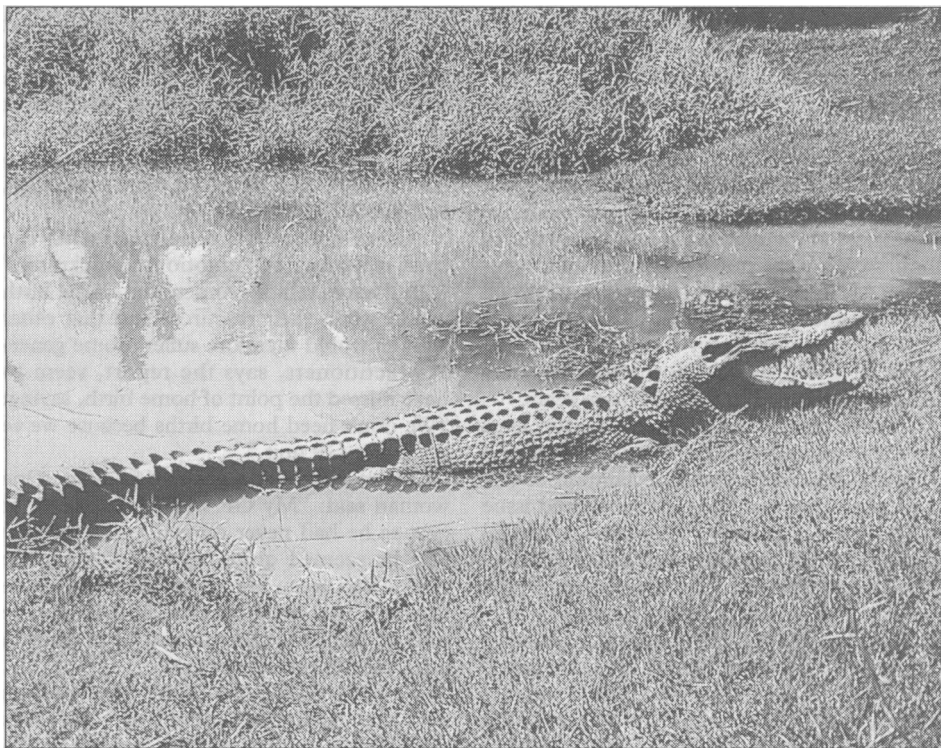
Hb Scuba uses unique elements of the crocodile haemoglobin cell which allow the crocodile to stay underwater on one breath of air for up to an hour. Mammals that dive, such as whales and dolphins, store the extra oxygen they need in their muscle myoglobin and have quite regular haemoglobin, but the crocodile's haemoglobin has evolved to bond with a waste product of respiration, bicarbonate ions, to help the unloading of oxygen to the tissues.

In crocodiles, as in humans, the carbon dioxide inhaled with each breath dissolves in the bloodstream to form bicarbonate ions. Crocodile haemoglobin has been found to contain amino acids which form bonding sites to the bicarbonate ions at the interface of the α and β globin chains.

When each molecule of haemoglobin binds to the bicarbonate ions its grip on its four oxygen molecules is loosened, which thus allows a far greater proportion of the oxygen inhaled to reach the tissues. This feedback control system could be used to improve the oxygen carrying capacity of artificial blood for emergency transfusion.

The Medical Research Council already has an artificial blood product undergoing evaluation by the Food and Drug Administration in the US, in partnership with the American chemicals firm Somatogen. This product, rHb1.1, has so far proved successful in human tests, and there are no immediate plans to replace it with the highly experimental Hb Scuba, according to Dr Kiyoshi Nagai, coinventor of both haemoglobins.

Crocodile blood has an amino acid sequence substantially different from that of humans, with only 60% confluence along the line. But Nagai and Hennakao Komiyama, with help from Gentaro Miyazaki of the University of Osaka and



Crocodiles can get hold of oxygen more easily than we can

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Jeremy Tame of the University of York, were able to isolate a mere 12 amino acids which could mimic the full bicarbonate effect when engineered into the human cell. Oxygen affinity is still 10 times as great as the crocodile's owing to differences in the cell's architecture, but this represents a considerable improvement over other substitutes and, indeed, over the genuine article.

Dr Nagai says that it will soon be possible to engineer the use of Hb Scuba in humans, but he and Komiyama are opposed to its use on ethical grounds.

"Natural human haemoglobin has evolved over millions of years to meet our body's requirements and it is the best molecule for our body as long as it is in its natural environment inside the red blood cell. However the haemoglobin molecule is not enclosed in the cell membrane when it is used as a blood substitute and therefore rHb1.1 and Scuba contain some modifications to mimic the properties of the natural haemoglobin inside the red cells," said Nagai.

The Medical Research Council's study of crocodile haemoglobin will also fuel the debate about the universal application of Darwinian selection to the evolutionary process.

Dr Max Perutz, who won a Nobel prize 30 years ago for his decoding of human haemoglobin by x ray crystallography, has advanced the theory of molecular evolution, which proposes that many of the developments in nature serve no particular purpose but that because they are not harmful these mutations have gained ground through pure luck.

A number of mutations in crocodile haemoglobin are apparently quite useless, which thus gives backing to the arguments of Dr Perutz.—OWEN DYER, freelance journalist, London

GPs accuse government of propaganda war

General practitioners have accused the British government of starting a propaganda war over the issue of work out of hours. The NHS Executive's action in sending *The Organisation of GP Out of Hours Services* to family health services authorities provoked an angry debate at last week's meeting of the General Medical Services Committee.

The committee's chairman, Dr Ian Bogle, has now written to all general practitioners pointing out what he claims are misleading statements in the document and encouraging them to write to their family health services authorities and members of parliament.

The document, which was issued without the GMSC's knowledge, is intended to enable authorities "to discuss with their GPs the organisation, including workloads, of the service in their area; and the potential impact of the out of hours changes, including the proposed night visit fee change." But two months ago the GMSC rejected what it called the Department of Health's derisive offer of a fixed payment of £2000 per principal for out of hours work and a new night visit fee of £9 (26 November 1994, p 1392). The government has failed to respond to repeated requests for the whole of the out of hours period to be priced rather than just the night visit period.

"The tone of the document is provocative," the deputy chairman, Dr John Chisholm, said. If the intention was to sell the changes by implying that the GMSC did not reflect general practitioners' views then the NHS Executive would not succeed, he

said. The document implied that the committee had been involved in its production and had agreed to the revised fees.

The NHS Executive says that demand by patients has grown "in part due to an increase in legitimate emergency calls for general medical services out of hours." But Dr Chisholm said that there was evidence that most of the increasing number of out of hours calls were not for genuine emergencies. Although 95% of contacts between patients and general practitioners take place during normal surgery hours, night visits have increased fivefold in the past 25 years and have doubled in the past three years.

The secretary of the inner London local medical committees, Dr Tony Stanton, said that the document was a declaration of war and suggested that the GMSC should issue its own document. Dr Fay Wilson, a general practitioner in Birmingham, called on doctors to telephone and fax their family health services authorities as well as to write.

The GMSC has been seeking an amendment to the terms of service to clarify that it is for general practitioners to decide whether patients need to be seen by a doctor and, if they do, when and where. The amending regulations are due to come into effect next month.—LINDA BEECHAM, *BMJ*

Childbirth trust calls for rights to home births

Pregnant women in Britain requesting a home birth have in some cases been intimidated by their general practitioner or even struck off the doctor's list, says a new report from the National Childbirth Trust. The report calls on the Royal College of General Practitioners to issue guidelines urgently to general practitioners "to clarify their responsibilities and the choices they should offer to women who want a home birth."

The report results from a national survey carried out by the branches of the National Childbirth Trust, and the findings are described as "dismal." The trust says: "The range of tactics used to put women off having a home birth varied from women being told that they were putting the baby at risk and they might bleed to death, to the idea that they would create a lot of mess and ruin their carpet."

Mary Newburn, head of policy research at the trust, said: "It is clear that some GPs are still threatening women. It is a shame to tarnish all GPs with this brush when so many are supportive, but it is time they put their house in order."

A total of 45 branches of the National Childbirth Trust reported members having been struck off their general practitioner's list for requesting a home birth. Mary Newburn said: "GPs should be honest with women and honest with themselves. If they don't have the skills and confidence to support home births they should not resort to blocking women's choice to hide it."

Only 17 of the 144 trust areas that responded to the survey reported that most general practitioners offered care for a home birth with community midwives. The report cites the experience of one woman who was told by her doctor that the last woman to have had a home birth, 30 years previously, had bled to death.

There are several reports of what the trust describes as "emotional blackmail," with doctors telling women that home birth would strain their resources and that other women would therefore suffer. Some general practitioners, says the report, seem to have missed the point of home birth, saying: "We don't need home births because we've got a nice GP unit."

There were some positive findings. One woman said: "My GP was a bit hesitant at first as he had never done a home delivery and he seemed quite nervous, but on the day he was great. He was so sweet; when he arrived I was shaky and the midwives were busy so he made the bed and he popped in a couple of times afterwards."

Dr Judy Gilley, one of the deputy chairs of the General Medical Services Committee, pointed out that general practitioners are under no obligation personally to provide maternity medical services, but, nevertheless, it is indefensible for doctors to remove women from their lists simply because they ask for information about home births. "Many general practitioners," she said, "are aware that their own skills as 'GP obstetricians' have become eroded because of the very low level of home deliveries in recent years."—CLAUDIA COURT, *BMJ*

Availability of Home Birth is available from the National Childbirth Trust, Alexandra House, Oldham Terrace, London W3 6NH, price £2.50.

Israel introduces national health insurance system

Nearly half the people polled on the day that a national health insurance system was introduced in Israel thought that health services would improve, although 35% thought that they would decline or had no opinion. Only about 5% of a population of five and a half million did not belong to one of the four public health funds when the scheme started on 1 January. But there was no freedom of choice among the insurers, and the largest fund, the Kupat Holim Clalit, was in financial difficulties. Owned by the Israel General Labour Federation for 70 years, the fund had been poorly run and faced a debt of 3bn shekels (£1.5bn). Nearly a quarter of the fees went to the federation for political and organisational use.

The new law guarantees hospital care, clinic consultations, low priced medicines, preventive dentistry for children, occupational medicine, in vitro fertilisation, treatment abroad if it is unavailable in Israel, physiotherapy, organ transplantation, and emergency care. In the future geriatric and psychiatric care will be provided. In 1995 the cost will be 14bn shekels (£7.05bn), from government expenditure, a health tax on income, and a tax on employers.

The tax rate is 3.1% for the first 2000 shekels (£1000) of monthly income and 4.7% for the remainder. No one will pay less than 47 shekels (£24) or more than 734 shekels (£367). A retired person with a pension will pay 88 shekels (£44). As middle and upper income groups—the ruling Labour party's prime constituency—were



Giving birth at home—the NCT is asking GPs to put their own homes in order

likely to have to pay more in health taxes than they had paid voluntarily in fees to a health fund the government has granted tax credits to working married women to soften the blow. Anyone who wants supplementary health insurance—for example, for long term nursing care, free choice of surgeon, or a private hospital room—will have to pay more. The health taxes will be distributed among the health insurers according to a modified capitation system.

Dr Bruce Rosen, the head of the health policy research programme at the Brookdale Institute, said that it was natural for the population to get cold feet before such a major change. Dr Rosen will supervise an independent team, commissioned by the Israeli parliament to monitor the scheme. "While most developed countries, except for the United States, offer universal health insurance, the Israeli model of managed care through health funds, competition, and a major government role in setting the rules of the game is unique," Dr Rosen said.

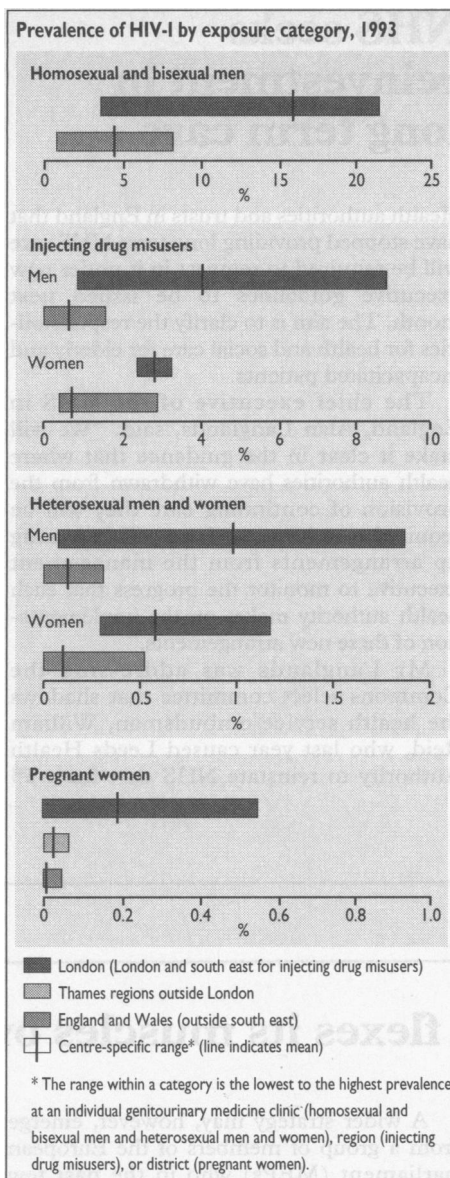
The critics of the changes say that as well as increasing the tax burden on the middle and upper classes, they might result in wealthier people seeking private care because the services offered will be inadequate. The second largest fund, Maccabi, has already aroused controversy by telling its doctors that they will receive a bonus if they prescribe fewer drugs and send fewer patients for diagnostic tests.—JUDY SIEGEL-ITZKOVICH, medical correspondent, *Jerusalem Post*

HIV infection concentrated in London

London continues to bear the brunt of HIV-1 infection in England and Wales, says the report from the government's unlinked anonymous screening programme published this week. The report estimates that in London 1 in 570 women at term are infected with HIV-1—40 times the prevalence in women delivering outside the south east. Among men attending genitourinary medicine clinics, 15.8% of homosexual and bisexual men and 1% of heterosexual men in London are positive for the virus compared with 4.31% of homosexual and bisexual men and 0.11% of heterosexual men outside London (see editorial, p 206).

Since the government's screening programme began in 1990 tests have been carried out on specimens of blood and saliva from injecting drug misusers. All specimens "are irreversibly unlinked from any patient identification before testing" so that individual results cannot be traced back to the patient.

Over the course of the programme the prevalence of infection has fallen significantly among homosexual and bisexual men attending two genitourinary medicine clinics in central London, from 22.3% in 1990 to 17.3% in 1993. Nevertheless, the report



draws attention to the relatively high prevalence of infection among young men in this group. In London 8.6% of those under 25 were positive in 1993; most of them will have acquired their infection in the past decade despite preventive campaigns. The prevalence of infection among injecting drug misusers is low—4% in men in London and the south east and 0.6% in men elsewhere.

The 40-fold difference in prevalence between London and elsewhere among pregnant women is thought to be due to a concentration in London of women who acquired HIV-1 infection in Africa: an estimated 70-80% of infections in pregnant women were acquired there. Because of this the report says that attention should be paid to the needs of families of African origin and to HIV education and prevention strategies that are sensitive to the needs of this group.

Among all groups tested, pregnant women who were HIV-1 positive were least likely to have been aware of their infection. In London the prevalence of HIV-1 infection in this group has risen significantly since 1990. The report concludes that the existence of substantial numbers of HIV-1 infected women in London, many of them with undiagnosed infections, is "a matter of

considerable public concern." It recommends making voluntary HIV testing of antenatal patients in London a priority, as avoidance of breast feeding, treatment, and mode of delivery may all affect vertical transmission.

The report strongly recommends targeting preventive activities at those whose behaviour puts them most at risk—homosexual and bisexual men (the highest priority), heterosexual men and women at risk of other sexually transmitted diseases, and injecting drug misusers. Dr Angus Nicoll, a consultant epidemiologist at the Public Health Laboratory Service's Communicable Disease Surveillance Centre and one of the team responsible for the report, said, "It's all very well for people like us to come up with these reports. The challenge now is for purchasers to combine national and local data to provide an idea of local needs for services."—TONY DELAMOTHE, *BMJ*

Unlinked Anonymous HIV Seroprevalence Monitoring in England and Wales (1995) is available from HMSO.

Europe cautious over genetics trials

Clinical experiments aimed at making genetic changes inheritable should be banned, the European Union has been advised. The advice comes from an independent group examining the ethical implications of biotechnology. After spending 15 months examining the highly complex issues raised by biotechnological advances the group concluded:

"Because of the important controversial and unprecedented questions raised by germline therapy, and considering the actual state of the art, germline gene therapy on humans is not at the present time ethically acceptable." But the advisers, chaired by Mrs Noelle Lenoir, the chairwoman of Unesco's international committee on bioethics, did give their blessing to somatic gene therapy.

They recommended that somatic gene therapy, which is widely seen as a vehicle for alleviating various genetic and acquired diseases, including cancer, should be encouraged at various levels by research being supported, and the organisation of training and exchange programmes for researchers and students.

Yet here too they urged caution in its development: "Because of its present risk assessment, somatic gene therapy should be restricted to serious diseases for which there is no other effective available treatment. The widening to other possible therapeutic indications could be considered, indication by indication, with an evaluation of the medical as well as ethical aspects."

The group also recommended local review systems and a national supervisory body to evaluate the experimental technology and advise on procedures to guarantee

quality without introducing undue delays in treatment of patients.

According to Mrs Lenoir: "It is premature at this stage to do clinical experiments on germline therapy. It is far too risky. We are dealing here with future human beings. At the present time there should be an ethical ban on germline therapy. We should be concentrating on somatic therapy."

The team of nine advisers covers a variety of disciplines—biology, genetics, philosophy, and theology—and all of the advisers are leading personalities in their particular field. The group was established at the end of 1991 by Jacques Delors, the previous European Commission president. Delors, whose 10 year term as president has just ended, is determined that the group's opinions, previously secret, should be made widely available to encourage debate on important ethical issues. The latest report is being sent to research centres and national ethics committees for their reactions.—RORY WATSON, *European*

Copies of the four page opinion can be obtained from Mrs I Arnal, Secretariat General, European Commission, 200 Rue de la Loi, B-1049 Brussels, Belgium.

NHS seeks reinvestment in long term care

Health authorities and trusts in England that have stopped providing long term NHS care will be required to reinvest in it under new executive guidelines to be issued next month. The aim is to clarify the responsibilities for health and social care for elderly and incapacitated patients.

The chief executive of the NHS in England, Alan Langlands, said: "We will make it clear in the guidance that where health authorities have withdrawn from the provision of continuing care they will be required to reinvest and we will be setting up arrangements from the management executive to monitor the progress that each health authority makes on the implementation of these new arrangements."

Mr Langlands was addressing the Commons select committee that shadows the health service ombudsman, William Reid, who last year caused Leeds Health Authority to reinstate NHS care for a 55

year old man who was severely incapacitated by a stroke and had been discharged to a private nursing home for which he had to pay. Mr Reid welcomed as "extremely positive" the assurance that authorities that had dispensed with long term provision would have to reinstate it.

Mr Langlands said that he hoped the new guidance would be better than the draft version, issued for consultation last year (20-27 August, p 498). It would clarify the health service's responsibilities for providing continuing care and set out what was required at local level. Patients would have simple written details of how discharge procedures worked, and at the end of their health service care they would be involved in planning their move to another social setting. The point at which NHS care came to an end would be decided by the consultant in charge, but thereafter the consultant would work with a multidisciplinary team to agree an appropriate package of care.

Mr Langlands said that while the guidance would make clear what the health service's responsibilities were, he did not foresee that a national template could be devised.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Focus: Brussels

European parliament flexes its muscles over health



The European Union's commissioner for social affairs, Pádraig Flynn, will be particularly keen to put January behind him. He is still

nursing his wounds after being ambushed by members of the European Parliament. The ambush was, however, only one sign of the parliament's new found interest in exercising its powers.

The ambush came during the European parliament's first ever public cross examination of the 20 new European commissioners. Flynn, whose work in his post over the past two years has generally been considered sound, ended up being judged on a lacklustre performance on the day. Even so he came through the ordeal, and, with his colleagues, has been voted a five year term in Brussels. Of some comfort was the fact that no one voiced any criticism of his handling of the union's health portfolio, which came into existence in November 1993. Here Flynn has indicated that consolidation, not expansion, is his aim. He does not want the European Union given greater powers over health. Instead he intends to concentrate on establishing networks, information exchange systems, and joint action as a way of encouraging cooperation between countries and lending them practical support.

A wider strategy may, however, emerge from a group of members of the European parliament (MEPs) who in the past few weeks have revived a cross party health group. The reins of the Health Intergroup have been enthusiastically picked up by its new chairman, Christian Cabrol, and the membership of the group is approaching 50. Cabrol, a French centre right MEP, a cardiovascular surgeon, and president of France Transplant, defeated Irish Fine Gael MEP and nurse Mary Banotti for the post.

Although the European parliament has a full time committee dealing with health, consumer, and environmental issues, Cabrol points out that the informal intergroup "offers an informal meeting place which otherwise might not exist for members who may be interested in health issues, such as the pharmaceutical industry or alcoholism, but who may be members of other parliamentary committees, like industry and agriculture rather than health."

The intergroup has selected five subjects for the months ahead: drugs, old age, tobacco, contraception, and the pharmaceutical industry. Individual MEPs have been delegated to draft reports on the health and policy implications of each subject, and in time these may emerge as legislative proposals.

Ken Collins, the British Labour MEP who chairs the full health and environment committee, supports the group's work. "It is a focal point for MEPs, non-government

organisations, and outside interests. It can identify issues and get them to the point of preparation when the health committee can take them up and perhaps turn them into legislation," he explains.

Others appreciate the group's informality. It allows members to voice opinions which might be frowned on in their particular parliamentary committee.

Much of the intergroup's continuity and expertise is provided by the European Public Health Alliance, a non-profit making body that brings together over 100 public health organisations. But it can also turn to outside opinion when preparing its reports, and the diversity of the backgrounds of the intergroup's members, ranging from doctors and nurses to university lecturers and journalists, is likely to ensure that these experts are not just from the medical profession.

Unlike Flynn, the intergroup would like to see wider European powers over health. Some argue that the Maastricht Treaty should be extended to guarantee minimum health delivery standards in hospitals across all 15 member countries. Cabrol is more cautious, but he also believes that "what we have in Maastricht is only the first step. We need to go further, but to do so prudently." This diversity of views promises spirited debates in the coming months as everyone prepares for next year's overhaul of the Maastricht Treaty.—RORY WATSON, *European*