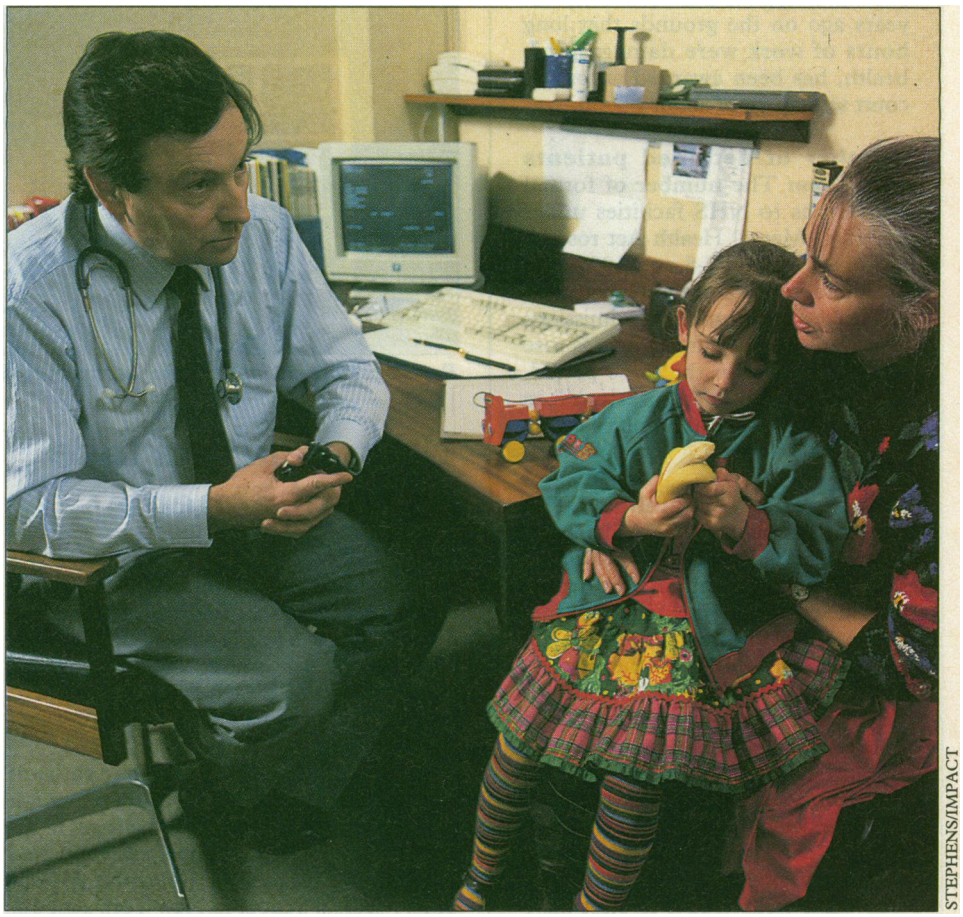
GPs to be balloted on proposals for night visits


STEPHENS/IMPACT

All GP principals will be balloted

Leaders of Britain's general practitioners are to seek clarification of the government's latest proposals for restructuring out of hours services and will ballot doctors "as soon as practicable." The ballot will go to all 32 000 principals in general practice. If the profession rejects the proposals the General Medical Services Committee (GMSC) will revive its plans for sanctions.

The new proposals were finalised just hours before the committee met on 20 April, after meetings with the health minister, Mr Gerald Malone, and officials of the Department of Health. The proposals include £45m in 1995-6 to develop rota systems and more cooperatives and to help rural and isolated doctors—for example, with costs of locum cover. There will also be a payment of £2000 for all principals for out of hours work and a consultation fee of £20 for all visits by principals, assistants, associates, and trainees during the hours for which the night visit fee is paid at present—that is, between 10 pm and 8 am. In addition, there is a commitment to allow general practitioners to transfer their out of hours responsibility to another general practitioner principal and a commitment to a campaign to educate patients.

The offer comes after weeks of frustration and discussions about possible sanctions (11 March, p 618). Last November the GMSC unanimously rejected a proposal for a basic allowance for out of hours work of £2000 and a uniform fee for night visits of £9 (26 November 1994, p 1392). There was also an offer of £15m for health authorities in England to invest in out of hours services.

About last week's offer the health minister said, "there should be absolutely no doubt that this is the government's final proposal," and he has specified that if doctors are asked for their views there should be no threat of disruption and sanctions.

Although the committee voted for a ballot by 55 votes to six, there was dismay that the offer left many questions unanswered. There is no new money. The proposed payments will come from a redistribution of the current night visit fee and an estimated underdelivery of the fee scale. The £45m will come from the existing NHS cash limited budget and will be paid to family health services authorities and health boards, which will decide how the money is to be spent. There is no guarantee that it will be ongoing—the minister says that the government will "review its commitment to the level of resources in the following years in the light of the usage of the money."

There has been no attempt to price the out of hours work as a whole as opposed to the night visit period. The GMSC believes that a five year high profile campaign is required to educate the public.

Dr Fay Wilson, a general practitioner in Birmingham, said that the offer was worse than the one in November. "The minister has withdrawn £15m of new money and stolen £45m from the rest of the NHS as a bribe to call off action by GPs."

Doctors must be asked for their views

But Dr Tony Stanton, secretary of inner London local medical committees, said that it would be a dereliction of the committee's duty not to ask the profession for its views. A former chairman of the GMSC, Dr John Ball, suggested that to hold a ballot on the proposal would give the document a dignity it did not deserve. But he reminded the committee that demand for night visits had doubled in the past three years and was likely to double again by the year 2000, when 40% of general practitioners would be women, who would demand a different structure. He urged the committee to concentrate on principles rather than details.

During discussions the GMSC's negotiators had recommended the introduction of a direct reimbursement scheme for developing out of hours services and had costed this at £100m a year. They suggested a sum which represented the value of out of hours commitment, estimated at about £10 000 per doctor.

The negotiators had proposed a standard arrangement for doctors to be relieved of their out of hours responsibility, whereby they would find a colleague willing to provide cover and obtain the approval of the family health services authority for the transfer of responsibility and pay. The Department of Health has specified that responsibility must be transferred to a named doctor and not to a cooperative or commercial deputising service.

Speaking after the GMSC's decision, Mr Malone said, "This package will enhance the quality of patient care at night by encouraging doctors to cooperate locally to provide high quality out of hours services.—LINDA BEECHAM, *BMJ*

Headlines

Junior doctor wins personal injury claim: Dr Chris Johnstone, the junior hospital doctor who sued Camden and Islington (then Bloomsbury) Health Authority six years ago on the grounds that long hours of work were damaging his health, has been awarded an out of court settlement of about £5000.

Number of detained patients increases: The number of formal admissions to NHS facilities under the 1983 Mental Health Act rose by 31% between 1987-8 and 1992-3 to 21 356, according to the Department of Health. The number of admissions to private mental nursing homes rose by 5% to 5703 in the same period, and the number of patients in Britain's three special hospitals fell by 7% to 1597.

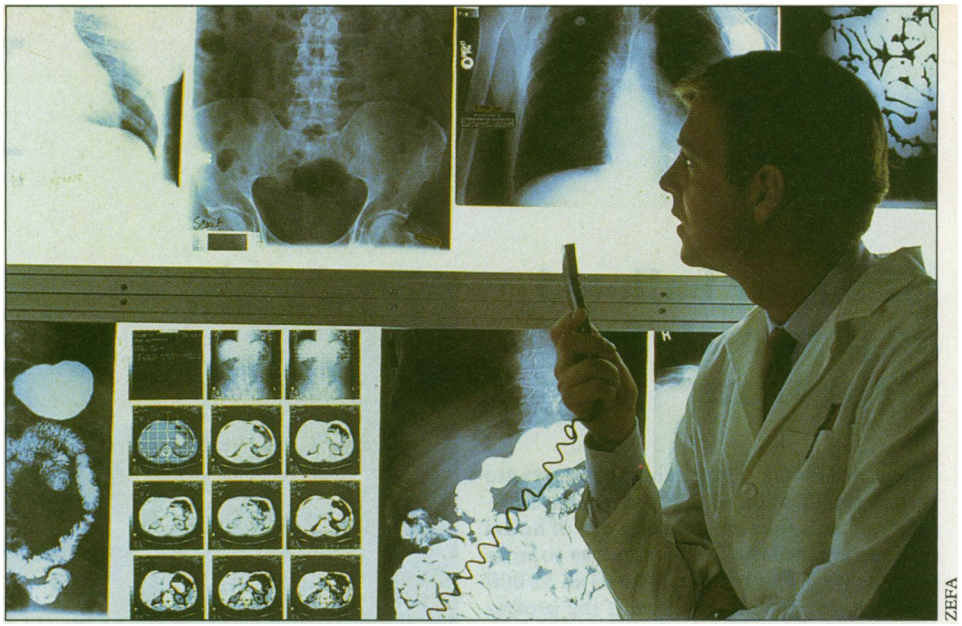
Police get DNA database: The world's first national DNA database, which has begun operating in Britain, has been hailed as an important breakthrough in the fight against crime. Up to five million records are expected to be held on the system, but DNA profiles will be kept only if the suspect is convicted or cautioned for a recordable offence.

Health and safety study launched: The management of health and safety in NHS short stay hospitals is to be studied by the National Audit Office. The eight week study, to start on 1 May, will look at the level and cost of accidents to staff, patients, and visitors at 30 hospitals in England and will report to parliament next year.

Consultant sent for trial: Mr Reginald Dixon, a consultant gynaecologist in Mansfield, has been sent for trial charged with carrying out an illegal abortion during a routine hysterectomy operation on a 35 year old woman in March 1993.

Scottish health visitors may join UNISON: The 840 strong Scottish Health Visitors Association has agreed in principle to merge with UNISON, Britain's biggest trade union with 1.3m members, despite approaches from the Royal College of Nursing and the white collar union MSF. Members will be balloted.

British smokers heavily taxed: British smokers are the third highest taxed in the European Union, after Denmark and Portugal. For a packet of 20 cigarettes £2.10 out of the £2.70 price goes on tax.



Radiologists are finding it tougher to get jobs in the US

US specialists face unemployment

American doctors who have finished training in some specialties are finding it increasingly difficult to get a job. The problem is especially severe in big cities like Los Angeles, New York, and Chicago and in a handful of specialties like anaesthesia, radiology, gastroenterology, and neurosurgery.

One newly trained ophthalmic surgeon was reportedly forced to measure refraction in an optical shop while seeking work in his specialty. A resident who had just completed her training in anaesthesiology at Mount Sinai Medical School in New York sent out 60 applications to New York hospitals before getting an offer of a job from Mount Sinai Hospital at a salary a fifth less than it would have been a few years ago.

Health maintenance organisations are widely blamed for their tight restrictions on the use of specialists' skills. Most of these organisations estimate that they need half of their doctors to be specialists and half to work in primary care.

Dr David R Dantzker, president of the Long Island Jewish Medical Center, a major training facility in New York City with 830 beds, said: "In some specialties we could probably turn off the tap for ten years and still have plenty." Dr Dantzker referred to anaesthesia, cardiology, gastroenterology, and some surgical subspecialties. He said that health maintenance organisations were reducing the need for both medical and surgical specialists and that this trend would continue, especially on the west coast, where enrolment in the organisations was highest.

Long Island Jewish Medical Center is not planning to reduce its training programmes, according to Dr Dantzker, but several of the medical subspecialty societies are assessing their staffing needs and considering ways to cut back training. Dr Dantzker said that this would have to be done carefully to avoid violating restraint of trade and antitrust laws.

The Reverend Thomas Crowder, associate dean for student affairs at the University of Miami School of Medicine, said that over half of its students had chosen primary care this year, evidently taking note of the shrinking demand for specialists in the medical marketplace. Those seeking residencies in the specialties generally found no problem, with 76% matched in the programmes of the top three choices—ophthalmology, orthopaedics, and anaesthesiology.

Despite the effect of health maintenance organisations in limiting the need for specialists in private practice, Rev Crowder thought that the need for them in academic and hospital settings would not decline. —FRED B CHARATAN, freelance journalist, Florida

Study links low dose radiation and Down's syndrome

A new study has provided evidence of a link between fallout from the testing of nuclear weapons and Down's syndrome. It found that women in the Fylde area of Lancashire had higher rates of births of children with Down's syndrome during periods when fallout was particularly heavy. The report also noted that a fire at the nearby Windscale (now Sellafield) nuclear power station in 1957 was followed by a surge in cases of Down's syndrome.

The research is by Dr John Bound, a former paediatrician at the Victoria Hospital, Blackpool; Brian Francis, of the Centre for Applied Statistics, Lancaster; and Dr Peter Harvey, pathologist at the Royal Lancaster Infirmary. The results appear in the latest issue of the *Journal of Epidemiology and Community Health* (1995;**49**:164-70).

The authors of the report analysed 167 cases of Down's syndrome among 12 015

total births in the region between 1957 and 1991. Other sources of radiation, such as *x* rays, were also taken into account. Women were divided into two age groups, over and under 35, to take account of the increased likelihood of women over 35 giving birth to a child with the syndrome.

The incidence of the syndrome was compared with statistics provided by the National Radiological Protection Board, which give estimates of the whole body radiation doses that the average Briton received each year from fallout from nuclear tests. Figures for radiation of testes in adults, which should match that of ovaries, were also compared. The researchers found that the two peaks of fallout, in 1958 and 1962-4, also coincided with peaks in the rate of cases of Down's syndrome, particularly in the older age group. At the time of the 1958 peak younger women were largely unaffected, but among women over 35 the incidence rocketed from 67 to 431 cases per 10 000 births. At the time of the 1962-4 peak the incidence among young women doubled from 7 to 14 cases per 10 000 births, while that among older women rose from 64 to 153 per 10 000.

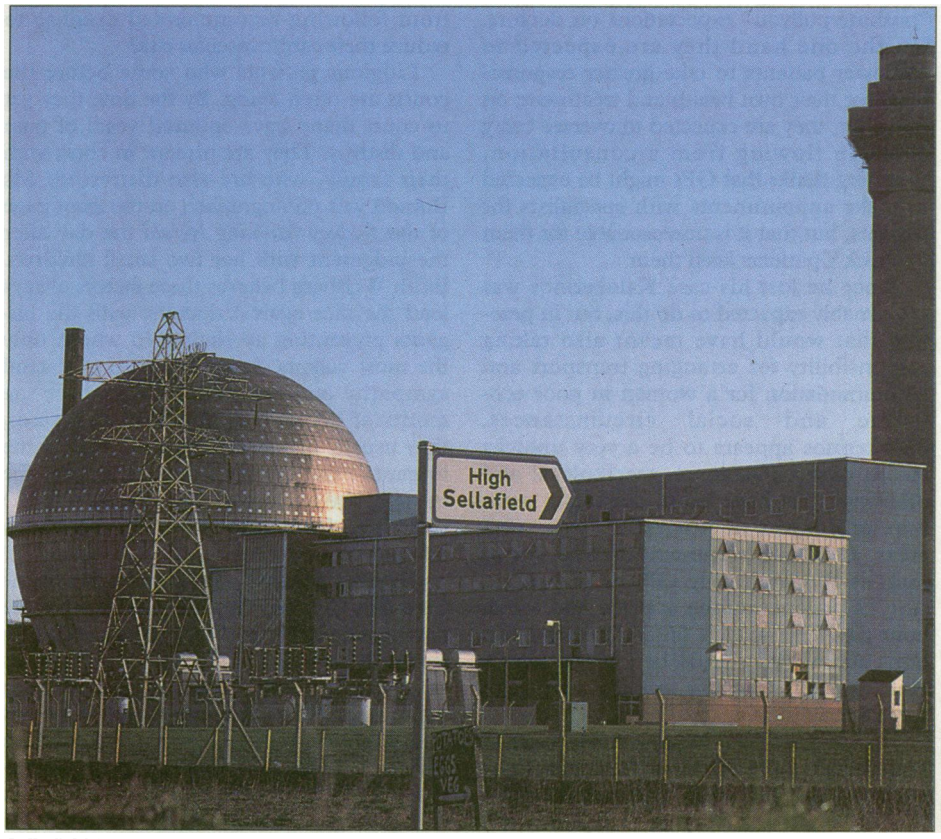
Dr Bound summarises: "Our findings are another piece of evidence that low dose radiation is an aetiological factor in Down's syndrome. It seems that the total dose you've had in your life is much more important than any individual dose. The greater susceptibility of older women suggests that these low doses may be the straw that broke the camel's back."

In fact radiation related to the nuclear industry is only a small part of the total dose of radiation that we absorb. Background radiation, whether from cosmic rays or ionising materials in the earth, accounts for 90% of the radiation we receive. Of the remaining 10%, about nine tenths comes from medical treatments and scans.

The women of the Fylde region were exposed to increasing amounts of diagnostic medical radiation throughout 1957-91, but this had little effect. The average dose went up by 14% each year at the Victoria Hospital—except for a steady period between 1957 and 1962—but this seemed to have had little effect on the rates of births of children with Down's syndrome. "We did have a progressive radiologist at the Victoria, who implemented all the recommendations about dose reduction and shielding that came out at that time," says Dr Bound.

Down's syndrome was first diagnosed in 1866, when natural radiation was the only kind of radiation to which the population was exposed. Although our exposure has increased by only about 10% since then, the recorded incidence of Down's syndrome has risen steadily through this century.

Dr Bound and his colleagues largely exonerate Sellafield (and Windscale), noting that the Fylde has a similar incidence of Down's syndrome to the national average. However, they suggest that a reactor fire at the plant in 1957 could have led to greater ground deposits of radioactive material during the 1958 peak. There was also a non-significant rise after the Chernobyl cloud passed by Fylde, although Dr Bound adds that Chernobyl generated only about a quarter as much radiation in the area as the nuclear tests of the 1950s and 1960s. Greater correlation between that nuclear accident and birth defects was found by researchers in Lothian and in Berlin.—OWEN DYER, freelance journalist, London



WOLMUTH/PANOS

Sellafield is largely exonerated

Dutch are split over donor consent

A dramatic fall in the number of transplant organs available in the Netherlands has led to controversial moves to adopt a donor system of assuming consent unless an objection has been registered. Last week the earliest possible date was due to be set for parliament to decide the issue, which has split the cabinet, patients' organisations, and Dutch society as a whole.

Health secretary Professor Els Borst-Eilers has recommended a compromise in which people can register for or against donating their organs. An active registration campaign aimed at 18 year olds is proposed. The next of kin would decide in cases in which a patient's wishes are not registered. This system would replace the current donor card, carried by a quarter of people over 18. Despite widespread publicity it has failed to meet the demand for transplants.

The Dutch cabinet has previously rejected pressure for a "no objection" system, which operates in Belgium, Austria, and Sweden and in which consent is assumed unless an objection has been registered. It argues that Dutch people are not in favour of it.

Yet there could now be a majority of MPs supporting the no objection system after a dramatic U turn by the opposition Christian Democrats. Meanwhile, the cabinet remains split over Professor Borst-Eilers's compromise so that there is no detailed government proposal.

Leading the call for a new law on donations is the Kidney Patients' Association, which points to a "dramatic fall" of 12% in the number of donor kidneys. This fell from 426 in 1993 to 378 in 1994. Meanwhile, the waiting list has grown to 1644.

Waiting times depend on the medical grounds for selection, but an average wait of four years seven months is quoted in the media. In 1994, 84 patients on the waiting list died.

Joost Alexander, director of the Kidney Patients' Association, said that the association was prepared to compromise but had been "bombarding" politicians since 1990 with arguments in favour of a no objection system. He argues that it is effective and is now accepted by two thirds of Dutch people, according to the latest opinion polls.

The Royal Dutch Medical Association does not go so far as to support a no objection system, but since 1990 it has called for a compromise that would replace the donor card with a central registration either for or against donation and assumes consent if the patient's wishes are not registered.

Koos Kranenburg, who chairs a national group of transplant coordinators, said that Dutch people may object to feeling forced to register their wishes.

His group has drawn up a national protocol and sent it to doctors and senior nurses in every hospital department so that they know how to act when they recognise a possible donor.—TONY SHELDON, freelance journalist, Utrecht

Equality guaranteed in cancer care shake up

Long term survival for people with common cancers in Britain could increase by 5-10% if they were all offered specialised care, said a government report this week. The report, from the Expert Advisory Group on Cancer, proposes a framework to provide better services for all.

"Whatever the level of resources, the overall results should get better in cancer services with these proposals," said Professor Karol Sikora, director of clinical oncology at the Royal Postgraduate Medical School in London. "Without a proper framework people will not get the best possible treatment and benefit from new advances. This report should end the cancer lottery."

The report argues that quality of care varies widely between different hospitals. It cites studies that show that for oesophageal, gastric, pancreatic, and breast cancer, survival in the short term is associated with units that treat a higher number of cases.

Peter Selby, professor of cancer medicine at the University of Leeds, said that the largest trials of the impact of specialist care in breast cancer showed an improvement in survival at five years of nearly 9%. "Half of women with breast cancer in London are seen in units that see fewer than 50 patients with breast cancer a year," he said.

Under the new framework three integrated levels of care will be set up. General practitioners will be involved in setting up rapid referral systems for patients with symptoms suggesting cancer and will act as their advocates.

The report emphasises the importance of a patient centred approach, with patients' views being taken into account and the best care being provided as close to their homes as possible.

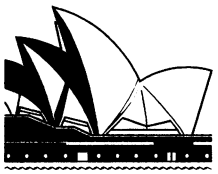
Cancer units will be set up in many district general hospitals. These units will deal only with common cancers, and surgeons will specialise in a particular anatomical area. A lead clinician in each unit will be responsible for supervising overall standards of care, including audit and education.

Rarer cancers will be treated in regional cancer centres, which will serve populations of about a million. Local units will transfer cases to the centres when they are unable to follow the required protocols for treatment or if patients need radiotherapy. Multidisciplinary teams will be available for almost all types of cancer and nursing staff will be expected either to have or to be training for a postregistration cancer qualification. Virginia Bottomley, secretary of state for health, said that the government accepted the report's recommendations.—LUISA DILLNER, *BMJ*

A policy framework for commissioning cancer services is available from the Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS

Focus: Sydney

"The first thing we do, let's kill all the lawyers"



A recent judgment in the New South Wales supreme court has added substantially to Australian doctors' fears that the medicolegal climate here may be going the way of America's. Last month Acting Justice Spender awarded 36 year old Cecily Burnett $A300 000 after she sued her general practitioner, Dr Archie Kalokerinos, for negligence over something that most doctors think he had little control over.

Ms Burnett had consulted Dr Kalokerinos, Bingara village's only GP, with heavy vaginal bleeding in 1991. He referred her to a specialist in Tamworth, two hours drive away, and personally phoned to make the appointment (referrals to specialists in Australia are frequently handed to patients to make their own arrangements). She claimed that she told him emphatically that, because of child care problems and not being able to afford either petrol or overnight accommodation, she wanted a referral to a specialist in nearby Inverell, only an hour away by car. Inverell is a small town with a population of 10 000 and has no obstetrician.

Kalokerinos admitted having previously made special arrangements for patients to travel to Tamworth on hospital buses, but, despite Ms Burnett's protestations about inconvenience, he made no alternative referral arrangements. Ms Burnett failed to keep her appointment, and what turned out to be cervical cancer remained undetected for nine months. She has since had a colectomy and cystectomy and has endured a wretched quality of life.

The medical profession's reaction to the judgment has been uniformly scathing. Dr Edith Weisberg, medical director of the Family Planning Association, points to the "pushme-pullyou" expectations on doctors. On the one hand they are expected to empower patients to take greater responsibility for their own health and treatment; on the other, they are expected to oversee every decision flowing from a consultation. Weisberg thinks that GPs might be expected to make appointments with specialists for patients, but that it is unreasonable for them to check if patients keep them.

Since he lost his case Kalokerinos was presumably expected to do this, but in practice that would have meant also taking responsibility for arranging transport and accommodation for a woman in poor economic and social circumstances. Kalokerinos appears to be a very unlucky victim of circumstances, medicolegal and otherwise, that have led to dwindling numbers of doctors in Australia's vast rural areas. Evidence presented in court shows that, as Bingara's only GP, he sometimes saw 72 patients during a seven and a half hour day. The judge's finding invites questions about who should be blamed for Dr Kalokerinos's inability to ensure that she saw a specialist in another town.

Justice Spender's judgment fell short of accusing Dr Kalokerinos of "conduct which was morally indefensible," while finding that he "failed in his duty to the plaintiff." Doctors might well ask what else the logic of that judgment will set a precedent for. Might patients claim negligence by their doctors if they found it inconvenient to follow a demanding drug regimen, if they felt the doctor's recommendations to quit smoking were not put to them sufficiently forcibly, or if their lifestyle precluded them from following recommended exercise to reduce their cardiovascular risk?

Litigious patients who come before the courts are often dying. By the time they get to court many have endured years of pain and distress. They are present in court with their family, who are also distressed. Ms Burnett was photographed on the front page of the *Sydney Morning Herald* the day after the judgment with her two small children. Edith Weisberg believes these factors always load the dice against doctors, with the litigants presenting as victims to whom only the most callous would not wish to extend sympathy and reparation. Whatever the merits of doctors' defences in such cases, they usually present in stark contrast to the litigants': the doctor with the future, the income, the insurance; the patient with the suffering, the imminent death, the family left to cope.

Heather Mitchell, deputy director of the Victorian Cytology Service, believes that the accelerating litigious climate in Australia can lead only to a rapid rise in health care costs as medical insurance costs are passed on to consumers: "Having made much of the law accessible only to the rich, lawyers seem intent on doing the same to the health system."—SIMON CHAPMAN, associate professor of public health and community medicine, University of Sydney.