# Cuban refugees injured themselves to get into the United States

Terri Rutter, *Boston*

Many Cuban refugees purposefully injured themselves or feigned illness in an attempt to be sent to the United States for treatment, according to doctors who treated them. Examples of the injuries include self inflicted burning, injection of diesel fuel, and ingestion of metal objects (*New England Journal of Medicine* 1997; 336:1251-3).

Frustrated by deteriorating economic conditions spurred by the collapse of the Soviet Union and dwindling economic support from Russia, thousands of Cubans attempted to sail to the United States aboard crude rafts only to be captured by US military forces and sent to Guantanamo Bay naval base, where they were held indefinitely.

While the US had previously allowed Cubans to immigrate relatively easily, in November 1994, Attorney General Janet Reno issued a policy allowing entry to only those under age 18, pregnant women, or anyone who had a medical condition that could not be treated at the base. The latter provision led to several hundred detained Cubans attempting to gain a "medical parole" by injuring themselves.

The majority occurred when a detainee copied another who had legitimately become ill or injured and who was consequently evacuated to the United States. For example, one young man was granted medical parole after he suffered severe burns on his hands after burning himself with melted plastic while moulding a sculpture. Several other people then burned themselves with melted plastic. After patients with severe prolapsed haemorrhoids were given medical parole, several people produced bleeding from their rectums by deliberately injuring themselves.

In other unique cases the doctors report, a man swallowed a large, metal hog ring, another injected diesel fuel into his scrotum, and five men cut their Achilles' tendons when faced with deportation back to Cuba because of criminal activity. The doctors also report that so many reported having symptoms of angina that a cardiologist was brought to the base for a three month term to conduct tests.

While a small hospital is located on the base already, the US military augmented its medical facilities in order to accommodate the influx of refugees; several clinics were brought in as well as two temporary hospitals equipped to perform surgery and to handle inpatients. The doctors write that these facilities were sufficient, and only the most extreme cases were sent to the United States for treatment.

When Ms Reno lifted the immigration ban in May 1995, allowing Cubans to enter the country, the authors report that cases of self-injury and malingering dropped dramatically, eventually vanishing altogether.

The authors from the Lackland Air Force Base, Texas, recommended that future humanitarian efforts conducted by the United States do not use a person's medical condition as a prerequisite for gaining entry into the country, or that a policy be instated that once people are treated in the US, they are returned to their own country.

But the case raises many problematic questions, several of which are raised by Dr Leon Eisenberg from Harvard Medical School in his accompanying editorial. Dr Eisenberg agrees with the authors' conclusion that the majority of the cases of self-mutilation and malingering discovered were not due to underlying psychiatric disorder, as is usually the cause of such behaviour, but were due to indefinite detainment. "But when behaviour that would be considered insane under ordinary circumstances … is motivated by a 'single-minded interest in an obvious goal', the social context for that behaviour must itself be insane," he writes.

BILL GENTILE/REX FEATURES

**Thousands of people tried to flee Cuba on crude rafts**

Father Thomas Wenski, who made several visits to Guantanamo Bay to visit Cubans—and previously to visit Haitians—detained there and whose parish in Miami includes a large number of Cuban immigrants, said the Cuban's behaviour "showed somewhat the desperation of the people." He said he has seen immigrants from China and Haiti who are detained indefinitely in a detention facility in Miami act similarly. "In desperate situations, people do desperate things," he said.

"This puts doctors in an untenable situation," said Susannah Sirkin, deputy director of Physicians for Human Rights in Boston. She compared it to the situation doctors face when confronted with hunger strikers. "The Cuban detainees were harming themselves to obviously avoid harm," but for the doctor it creates a paradox of being obligated to treat while knowing that to do so just perpetuates the situation that led to the injury.

The authors, too, point to this conflict. The situation had a "profound" effect on the doctor-patient relationship, which resulted in the trust that usually surrounds that relationship being replaced by "suspicion and deceit, as the patient attempted to 'fool the doctor' into granting medical parole."

Biomedical ethicist Arthur Kaplan, director of the Center for Bioethics at the University of Pennsylvania, said that conflicts of interest are always difficult, but that the doctors "do have an obligation to patient's health" and that the patient is "entitled to a disclosing discussion." The authors also write that the "added disadvantage of language and cultural barriers," as well as not having medical records influenced the determination of "conditions warranting their placement on the medical parole list." Dr Kaplan said, however, that the doctor should "go as far as you can to maximize patient health while minimizing the role of conflict." □

## *In brief*

**Cigarettes to be classed as drug in United States:** A federal judge in North Carolina has ruled that cigarettes can be classified as drugs and, as such, be regulated by the Food and Drug Administration. The FDA would be able to limit sales from vending machine and impose penalties on shopkeepers who sell tobacco to minors but would not be able to control promotion and advertising.

**Southern Africa moves to ban landmines:** Military and foreign office officials from the 12 states of the Southern Africa Development Community, who met in Harare, Zimbabwe, last week, called on their governments to end all new deployments of landmines and to ban the use, production, stockpiling, and transfer of these weapons.

**Call to halt enrolment of medical students in Italy:** The Italian federation of medical registrars has asked medical schools to halt student enrolments for a year because there are too many doctors. Out of 325 000 doctors, 80 000 are unemployed. Italy has almost three times as many doctors as Britain.

**Leading British doctors urge people to vote Labour:** Fifty nine doctors, including former BMA chairman Dr John Marks, past president of the Royal College of Physicians Sir Douglas Black, and Surrey University Dean of Medicine Professor Vincent Marks, made a public appeal for voters to elect a Labour government to protect the NHS. In a letter to the *Daily Mirror* they say that the Conservative reforms are eating away at the NHS like a cancer.

**Health of the Nation target on obesity unlikely to be met:** A report from the NHS Centre for Reviews and Dissemination at York concludes that, since there are health benefits associated with even modest reductions in obesity, weight loss programmes should not necessarily aim to attain an ideal body weight. It also says that long term follow up is necessary as most people regain weight a few months after treatment.

# Japan to allow organ transplants

Jacqui Wise, *BMJ*

The lower house of the Japanese parliament has voted to officially recognise the concept of brain death, paving the way for heart transplants to occur for the first time in the country.

Japan's major law making body voted by 320 to 148 to allow a person to be declared dead when his or her brain stops functioning. Previously, a person's heart had to stop for death to be declared, which made heart transplants impossible.

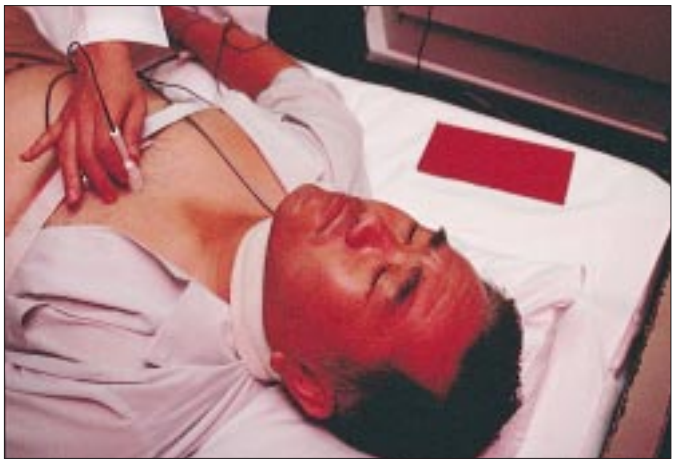
For many years the issue was considered to be too controversial to bring to parliament. Although Japan's two main religions, Buddhism and Shinto, do not ethically object to the concept of brain death, there has been considerable cultural resistance to donating or receiving organs. Many people believe that a person's body and soul are linked and that, in giving up an organ, a person gives up his or her soul. There are also superstitions about "defiling" the body before it reaches the next world.

Doctors say that this resistance to organ transplants has cost thousands of lives that could have been saved. In one of the most technologically advanced countries of the world many critically ill patients have had to be flown to the United States and elsewhere for what has become a relatively routine operation.

The upper house of parliament must still approve the bill, which is believed to be likely but not certain. However, approval by the powerful lower house is seen as a major landmark in public opinion that could have enormous effects on Japanese medicine. Pakistan and Poland are the only other major countries that do not designate brain death as actual death in law or practice.

There has not been a single heart operation in Japan since 1968, when a Japanese surgeon who performed the operation was investigated for murdering the donor. Even though the doctor was not found guilty, the long court case put a stop to all further operations.

The legalisation of brain death means that thousands of patients could be taken off artificial life support. The Health and Welfare Ministry estimates that more than 8000 people in Japan would be declared brain dead



P JONES GRIFFITHS/MAGNUM PHOTOS

**Resistance to organ transplants in Japan has cost many lives**

# Heart transplant pioneer cleared

Clare Dyer, *legal correspondent, BMJ*

The team headed by the heart transplant pioneer Sir Magdi Yacoub was cleared of negligence in the High Court last week for failing to warn of the risk that a heart transplant operation could leave a child severely brain damaged.

Kevin and Linda Poynter sued Hillingdon health authority in West London, claiming they would not have allowed their son, Matthew, now 10, to undergo the operation at Harefield Hospital had they known of the risk. They told the court they were opposed to transplantation in principle and had been put under pressure to allow the operation.

Matthew was only the 30th child in Britain to have a heart transplant and, at 16 months, one of the youngest. The brain damage is thought to have occurred after he suffered a cardiac arrest while being anaesthetised and his heart had to be kept going for 30 minutes by massage.

The judge, Sir Maurice Drake, accepted that the couple were not warned of the risk of brain damage. Sir Magdi said in evidence that he would not have warned of the risk–less than 1%–unless he had been specifically asked.

Sir Maurice, following the 1985 House of Lords decision in Sidaway *v* Bethlem Royal Hospital Governors, held that the transplant team was not negligent because a responsible body of medical opinion in 1987, when the operation was performed, would not have warned of such a small risk. Since 1990 Harefield Hospital has warned parents of the risk of brain damage.

The majority of law lords in Sidaway seemed to indicate that a doctor was obliged to answer fully if asked a question about a specific risk, but doubts have been raised about this interpretaion in later cases. Sir Maurice said: "Even if the parents had asked directly about the risk of permanent brain damage, which I find they did not, it is by no means certain that doctors would have been under an unqualified duty to tell them of their assessment–probably less than one percent."

The judge rejected the Poynters' evidence that they would not have consented to the operation had they known of the risk. That finding means that they failed to establish that the alleged negligence caused the injury, and would therefore have lost the case even if the doctors had been found negligent.

The Poynters' solicitor, Tom Osborne, said they had not wanted to go to court, but had felt forced to because the health authority had never explained what had happened and had rejected offers to have the case dealt with by alternative methods, such as mediation. □

# Hay fever drug to become prescription only

Jacqui Wise, *BMJ*

The hay fever treatment terfenadine is to become a prescription only medicine in Britain after concerns about its safety.

The Committee on Safety of Medicines said that when terfenadine is used as recommended it has a good safety record, but when it is taken by patients with heart or liver disease, in overdose, or with drugs which interact it can produce serious or even fatal cardiac arrhythmias. There have been 33 serious cardiac arrhythmias, including 14 deaths linked with taking the drug, most of them since the committee first issued warnings in 1992.

In the past couple of months the drug has been taken off the market in France, Greece, and Luxembourg, and the Food and Drug Administration is in the process of banning the drug in the United States (25 January, p 248).

Terfenadine, a non-sedating antihistamine, is one of the most widely used treatments for hay fever, taken by around 2.3 million people in Britain. There will be a six week period of consultation, and the drug is likely to be removed from sale in pharmacies in two to three months' time.

MARK CLARKE/SCIENCE PHOTO LIBRARY

**Terfenadine is one of the most widely used hay fever treatments**

Terfenadine is a prodrug which is converted in the body to an acid metabolite (fexofenadine) that is responsible for the beneficial effects of the drug. Usually terfenadine is completely metabolised by the liver and is not present in the systemic circulation. However, if metabolism is inhibited or overloaded the parent drug reaches the circulation and causes prolongation of the QT interval in an electrocardiogram. This predisposes to ventricular arrhythmias, which may progress to ventricular fibrillation and death.

The Europe-wide medicine agency is currently reviewing the safety of terfenadine and trying to reach a consensus between the 15 countries in the European Union. As well as in Britain, the drug is available over the counter in Ireland, Germany, and Denmark.

Professor Michael Rawlins, chairman of the Committee on Safety of Medicines, said that the move had not been prompted by the bans in other countries. Instead he said that the final straw had been the finding that the drug should not be taken with grapefruit juice. Grapefruit juice contains a family of substances called psoralens which increase concentrations of terfenadine in the blood.

Professor Rawlins said: "Because of the increasing complexity of the precautions needed for its safe use, it is unlikely that terfenadine can be used as safely as alternative non-sedating antihistamines without medical supervision."

Professor Rawlins emphasised that the drug was safe provided that it was used appropriately. It should not be used by patients with heart or liver disease. Adults should take no more than 120 mg a day. It also should not be taken with ketoconazole, itraconazole, or related imidazole antifungals or with erythromycin, clarithromycin, or related macrolide antibiotics.

The committee says that if there is any doubt doctors should recommend an alternative non-sedating antihistamine which does not require the same precautions—for example, cetirizine or loratadine. Astemizole may also produce serious cardiac arrhythmias, but the committee says that there is insufficient evidence to justify changing its prescription status, although this is being kept under review.

The Food and Drug Administration recommends that patients use the active metabolite of terfenadine—fexofenadine. However, although this drug has recently become available in Britain, the Committee on Safety of Medicines says that there are not yet enough data to recommend it. □

# US endorses testing for cystic fibrosis in pregnant women

Norra Macready, *Irvine, California*

Doctors should offer testing for cystic fibrosis (CF) to people with a family history of CF and the partners of people who have the disease, according to recommendations issued last week by a panel convened by the National Institutes of Health. The panel also recommended that CF testing be offered to pregnant women and couples currently planning a pregnancy.

However, the panel did not advocate testing for the general population, nor did it recommend that newborn infants be screened for CF. Mass screening of newborns does not seem to have any clinical merit, said panel member Ezra Davidson, professor of obstetrics and gynaecology at the King Drew Medical Center and Charles Drew University of Medicine and Science, Los Angeles. There is no evidence that early diagnosis in the newborn alters the course of the disease, so mass screening would incur extra cost with no perceived clinical benefit, unless a sibling already had CF.

The recommendation against mass screening of newborns is especially true for regions that have heterogeneous populations, Professor Davidson explained. Cystic fibrosis is the most common genetic defect in white people. The screening test is more than 90% accurate in people of northern European descent, in whom the incidence of CF is about one in every 3000 live births. The incidence is also high in Ashkenazi Jews and a few other groups, so mass screening may make more sense if a population is primarily Caucasian.

However, he said the test is only 70-75% accurate in black people, in whom the incidence of CF is one in every 15 000 live births. In Asians the disease occurs in one in every 32 000 live births. Currently, more than 25 000 Americans have CF, with about 850 new cases diagnosed each year.

According to Professor Davidson, the average age at diagnosis is 6-8 months, with two thirds of all cases being diagnosed before the age of 1 year. Some patients have severe manifestations, while others have relatively mild disease with presentation during adolescence and young adulthood. The outcomes are similarly variable, ranging from early death to mild atypical disease in the second and third decades of life and, rarely, a normal length of life. About 90% of people with CF die of pulmonary complications.

Currently, the median length of survival is 30.1 years, up from 18 years in 1976, thanks mostly to aggressive management of pulmonary, pancreatic, and intestinal complications. □

# Call for European cooperation in research

Tony Sheldon, *Utrecht*

European cooperation in medical research is vital in order to introduce innovations in a cost-effective manner, speakers argued at an international conference on innovative research and appropriate health care for European citizens.

Chief medical officers and health ministers of the 15 European Union countries attended the meeting hosted by the Netherlands, the current EU presidency holders. Views will be taken up by the EU's recently launched Fifth Framework programme for research and technology development, when research ministers meet on 15 May.

The EU commissioner for education and science, Edith Cresson, said that 25% of Europeans will be aged over 60 by the year 2020. As a result Europe needed to define rigorous yet careful cost containment policies.

Only research can provide an objective base for policies, she argued, and collaboration on an EU level, with its critical mass of 400 million people, had advantages. European diversity meant EU-wide epidemiological studies had great benefits and multicentred research could be carried out, such as the current investigation of variations in perinatal mortality in 10 EU countries.

The Dutch health minister, Professor Els Borst-Eilers, said the large scale European research on prostate cancer screening was an example of where the international sharing of knowledge could improve cost effectiveness. "Cooperation in the field of research is an excellent opportunity to show the added value of the European Union," she said.

Professor Borst argued that with the fast emergence of chronic and infectious diseases, together with rapid scientific developments and member states struggling to control costs, the credo for the next century must be "doing the right things right."

A long term advocate of evidence based medicine, she also argued that research needs to be applied with a stronger emphasis on setting standards and monitoring outcomes. "We ought to row less and steer more," she said. She argued that in the past innovations had saved costs—for example the use of antibiotics for treating stomach ulcers and tuberculosis. □

# GP reveals patients' secrets in pub

Clare Dyer, *legal correspondent, BMJ*

A British GP who revealed his patients' secrets in a pub drinking session was last week found guilty of serious professional misconduct by the General Medical Council.

Norman Shannon, who practised at Water Orton, Wishaw, near Birmingham, had drunk five pints of Guinness before he blurted out to a relief manager that the pub landlord and landlady, Philip and Carol Pallett, who were away on holiday, had received infertility treatment and that their two children were conceived by donor insemination. The conversation was overheard by staff and customers and by Mrs Pallett's 17 year old daughter, who was unaware that her half brother and sister, aged two and four, were not conceived naturally.

Dr Shannon's case was referred to the GMC's health committee, set up in 1980 to deal with doctors whose ability to practise is impaired by drug or alcohol related problems or by mental illness. The committee's twin aims are to protect the public and help the doctor towards rehabilitation if possible.

The professional conduct committee placed conditions on Dr Shannon's registration, banning him from treating patients for three years or until the health committee accepts responsibility for his case or the case comes back to the professional conduct committee. He is also obliged to undergo psychiatric treatment. Two medical examiners will be asked to report to the health committee on whether Dr Shannon's ability to practice is impaired. If so, the committee will assume responsibility, and it could lift the ban on practice within the three years if Dr Shannon overcomes his alcohol problem.

During the three day hearing, Rosalind Foster, counsel for the GMC, said: "A doctor is a doctor, in or out of surgery, and must act in accordance with the standards expected of him. Some might think that a boorish outburst in a pub is even worse than a disclosure in a surgery context."

Dr Shannon's counsel, Mary O'Rourke, told the committee: "This is not a wicked doctor that is here in front of you. It is a sick doctor."

Mr and Mrs Pallett, who had decided not to tell their daughter and son how they were conceived, had already decided to leave their pub, the Cock Inn, in Wishaw. But their embarrassment was so acute that they felt they had to make a fresh start elsewhere and moved to Kettering in Northamptonshire. Their identities were not disclosed during the hearing, but they later agreed to be named and photographed by a national newspaper. □

HEATHCLIFF O'MALLY/NATIONAL NEWS

**Dr Shannon's case was referred to the GMC's health committee**

# HIV transmitted by bone graft

Helmut L Karcher, *Munich*

**A leading transplantation centre in Germany must pay compensation to a man who developed AIDS after receiving a bone graft from a donor who was a drug misuser.**

**The Medical University of Hanover was sentenced to pay DM300 000 (£108 000, $176 000) in compensation to a 58 year old man. In January 1985 the man, who had a clavicle fracture, received a transplanted lyophilised bone chip from a donor who was a drug misuser, and who had died from drug overdosage. The donor was not tested for HIV—at the time there were only around 150 cases of AIDS in Germany. At least two more patients, out of 12 who received bone transplants from the same donor, later died from AIDS.**

**The Superior Court of Hanover decided there was no doubt that the plaintiff had been infected with HIV via the bone graft. Although the judges conceded that in 1985 it was not known that viral diseases could be transmitted by lyophilised bone grafts, the court insisted that the donor's drug addiction should have been a warning signal to doctors. Medical consultants in court also confirmed that in 1985 there was already a rising debate going on whether AIDS could be transmitted by other media than blood.** □

**Richard Smith** reports on the 2nd European Forum on Quality Improvement in Health Care in Paris, organised by the *BMJ* and the Institute for Healthcare Improvement in Boston

# Understanding customers' needs is the key to improvement

Projects with a deep understanding of customers' needs are 16 times more likely to succeed than those that do not, according to a review of quality improvement projects.

David Gustafson, professor of industrial engineering and preventive medicine at the University of Wisconsin, said that comparisons between successful and failed projects showed that understanding customers' needs was the most important principle underlying quality improvement and seemed to overwhelm all others.

The principles of quality improvement are supported by good evidence, Professor Gustafson told last week's forum which was attended by 630 delegates from 38 countries. These principles have been derived from more than 50 years of work, most of it in sectors other than health care (see box).

Professor Gustafson cited two sources of evidence of effectiveness—a review of over 600 quality improvement projects, roughly half of which succeeded and half failed, and detailed case studies of 15 improvement projects in health care that had been nominated as outstanding successes.

Projects that used "benchmarking"—looking at other organisations or even other industries to find best practices—were four times more likely to succeed than those that did not. Looking to other industries seems to be especially important, said Professor Gustafson, and he criticised those within health care for rarely doing so.

Another principle that was associated with a fourfold increase in the chance of succeeding was for the organisation to focus on quality. It seemed, said Professor Gustafson, particularly important to be tough on people and insist that they could achieve high quality. Managers providing support for improvement was associated with a more than twofold increase in the likelihood of success. The other principles were not associated with significant increases.

The detailed studies of 15 nominated successes showed that most of the principles were evident in all cases. Working with suppliers as partners was, however, evident in only four cases, and constancy of purpose and empowering employees did not seem to be important in two cases. Professor Gustafson conceded that weaknesses with the second study, which was funded by the United States Agency for Health Care Policy Research, were that it had not examined failures and had no controls. □

Next year's conference will be held in Vienna. For more information contact Marchella Mitchell on 0171 383 6478 or email: 106005.2365@Compuserve.com

**Principles of quality improvement**

- Constancy of purpose within the organisation and with the project
- Responding to customer (or patient) needs
- Focusing on quality as important
- Focusing on processes
- Using data and statistical analysis
- Empowering employees to improve quality
- Support from senior managers
- Benchmarking (looking at other organisations or even other industries to find best practices)
- Continuously improving
- Working with suppliers as partners

# Quality can be raised and costs reduced in hospital care

**Reviewing and improving a practice protocol is the key to improving quality, according to the executive director of Intermountain Health Care—a health system which provides health care for 20 000 people in Utah.**

**Brent James told the meeting that understanding the methodology of improvement is essential for success. Doctors at Intermountain Health Care receive at least nine days' training in the methods. They think simultaneously about the physical, service, and cost outcomes of what they are doing and work with practice protocols to improve care.**

**Dr James said the first two parts of this process—reviewing the medical literature and generating a first pass protocol—are familiar. It is the third part—implementing, improving, and validating the protocol—that is unfamiliar.**

**Using the example of improving ventilator management for patients with adult respiratory distress syndrome, Dr James described how the third part of the process works. Doctors working with a 200 page protocol were told to ignore it when their clinical judgment told them the protocol was wrong. All of the team managing such patients then met once a week to examine in detail the times when doctors had gone against the protocol. Using various decision aids, the team would then decide that the protocol was right or wrong or that the difference between a doctor and the protocol was "random noise." If the protocol was wrong it was changed.**

**The result of this process was that after eight patients were treated, instead of only 40% of decisions being based on the protocol, over 90% were. It was never 100%, said Dr James, but it stayed at close to 90%. The result was that survival went from 9.5% to 44%, time in the intensive care unit went down, and costs were reduced.**

**Dr James said that the process has been implemented throughout the hospital and in the community, which has raised quality of health care and saved millions of dollars.** □

# Leaders need to be able to manage change

The ability to manage change is the most important characteristic of successful leaders, said Rosabeth Moss Kanter, professor of business administration at Harvard Business School.

Professor Kanter told the meeting that the ability to manage change depends on seven essential skills. Firstly, leaders must be able to tune into the environment and be aware of the gap between what could be done and what is being done. "Effective leaders pay more attention to what doesn't work than to what does work. They are never satisfied with how it is today."

The second skill is to be able to challenge assumptions about the current reality. "Shake things up, be playful and irreverent," said Professor Kanter. Thirdly, successful leaders must be able to communicate a compelling vision of where they want an organisation to go, and, fourthly, they must have the ability to create a coalition of backers and supporters. Fifthly, they must build the team that will make the changes happen. "It will," said Professor Kanter, "always need a team."

The sixth essential skill is to persist and persevere. Professor Kanter said: "Everything can look like a failure in the middle." The final skill is to share the credit and recognition for success.

"All improvement demands change," said Don Berwick, paediatrician and chief executive officer of the Institute for Healthcare Improvement, Boston. □

# Protest over sale of national mental hospital in the Philippines

Adam Easton, *Manila*

Health workers in the Philippines have described a government plan to relocate its national mental hospital to a site which is malaria infested and near a cliff as "insane."

The government wants to convert the 49 hectare site of the state run National Centre for Mental Health in Manila into a commercial, residential, and recreational complex. The Council for Health and Development said the sale would mean 4000 mental health patients would need to be relocated.

One of the areas planned for relocation, Pililla, which is 60 km away from the present site, is malaria infested and near a cliff, the council said. The chair of the council, Dr Eleanor Aquino-Jara, said: "This is yet another insane move of the government as it systematically abandons its responsibility to care for its citizens, including the mentally ill."

The Department of Health will be paid a £3m ($4.8m) "disturbance fee" for moving the mental patients away from their familiar surroundings. Bidding for the land, in Manila's Mandaluyong City, begins on April 29. Many business groups are said to be interested in buying the land.

Dr Jara fears that the sale of the site is part of the government's plan to privatise certain state run health services. At present, health services are free to ordinary Filipinos in state run hospitals. Patients only have to pay for medication. But the government is keen to privatise some health services. Many state run hospitals already have privately run security and maintenance services.

Dr Jara said: "Privatisation of health services will definitely result in further commercialisation of health services, where patients with no money will not be treated. No pay, no cure."

But health secretary Carmencita Reodica has denied the claims. "This is not part of the privatisation programme," she said.

The government is reportedly planning partly to privatise four state specialty hospitals—the Philippine Heart Centre, the National Kidney Institute, the Philippine Children's Medical Centre, and the Lung Centre of the Philippines.

Ms Reodica defended the decision to relocate to Pililla and added it was the best of the choices given to the government run hospital. She said: "The Pililla site has good roads. Besides, the place is in a regional growth area."

The Philippines' senate president, Protempore Bias F Ople, has filed a resolution asking the senate committee on health to investigate the plan.

Mr Ople said the inquiry was needed because of the lack of a clear cut policy on the privatisation and commercialisation of medical services. He said: "It is the duty of the state to provide health services to these patients. There is really no urgency for this conversion."

He added: "There should be limits to the power of the state to privatise when it involves the welfare and wellbeing of the sick." □

## *Focus: Sydney*

# Confusion over radiation risk from phone towers

Simon Chapman

After growing protests from residents about the alleged dangers from radio frequency radiation from mobile phone towers, several local councils in Sydney have issued regulations on the distances away from buildings that towers can be located.

Note it is "distances" not "distance." For example, according to the rules of one council, no tower can be placed within 300 m of your house. But the towers can come as close to your workplace as specified in any deal struck between your employer and a phone company. They can plonk one right outside your office or factory window.

The council stated that it had considered the "potential health impact." Presumably it believes that workers are more robust than residents in resisting the alleged ill effects of radio frequency radiation.

What the thousands who both work and live in the area are supposed to make of this is anyone's guess. There's more: schools, childcare facilities, hospitals, or, intriguingly, centres for elderly people or recreational facilities won't have a tower within 450 m of them.

Further layers have been added to this emerging hierarchical model of radiation susceptibility. A golfer or a picnicker apparently cannot resist radiation like a worker can. Along with infants, children, and sick and elderly people, golfers get an extra 150 m buffer zone. When they go home, of course, all these people can snuggle up to towers that are 150 m closer.

Given that children spend more time at home than in school, the two different minimum distances cannot reflect any rational concern to minimise exposure.

If there is any group who would escape the health consequences of exposure, it is elderly people: they won't be around to suffer any consequences. Lumping them in the same category as infants suggests the intriguing possibility that there might be a hotbed of reincarnationism inside the councils.

When it comes to anything industrial, imposed, and close to populations perceived as vulnerable, many in the community demand zero risk—a notion that exists only in the minds of those who are totally risk averse.

On hearing that towers can be located nearer to factories and homes than to schools, many will assume that this is a sensible policy despite its internal contradictions. Instead, the misplaced precision of the guidelines reflects a confused interpretation of the little that is known about the true level of long term risk of radio frequency radiation (small, with few warning bells to justify any extreme vocabulary of risk) and of risk communication principles.

The starting point of any sane policy would place the towers equidistant from any residence, workplace, or gathering place.

But the unsung side of the health debate about mobile phone towers has nothing to do with any possible effects from radiation.

There are countless examples of mobile phones being used to call for help—in breakdowns on major and isolated roads, to call ambulances to injured people; by people fearing assault; by families who give an elderly, wandering relative a phone so that he or she can be traced. Not to speak of the health promoting aspects of allowing ordinary, unexceptional contact between people.

Any decisions by governments that reduce the reach of the mobile phone network that claim to be driven by public health concerns must be a factor in the loss of such benefits; these must be balanced against the estimates of what even the doomsayers calculate as modest rises in dreaded diseases like leukaemia. □