Plague case shows signs of multidrug resistance

Jacqui Wise, *BMJ*

High level resistance to multiple antibiotics has been reported in a strain of *Yersinia pestis* isolated from a patient with bubonic plague from Madagascar.

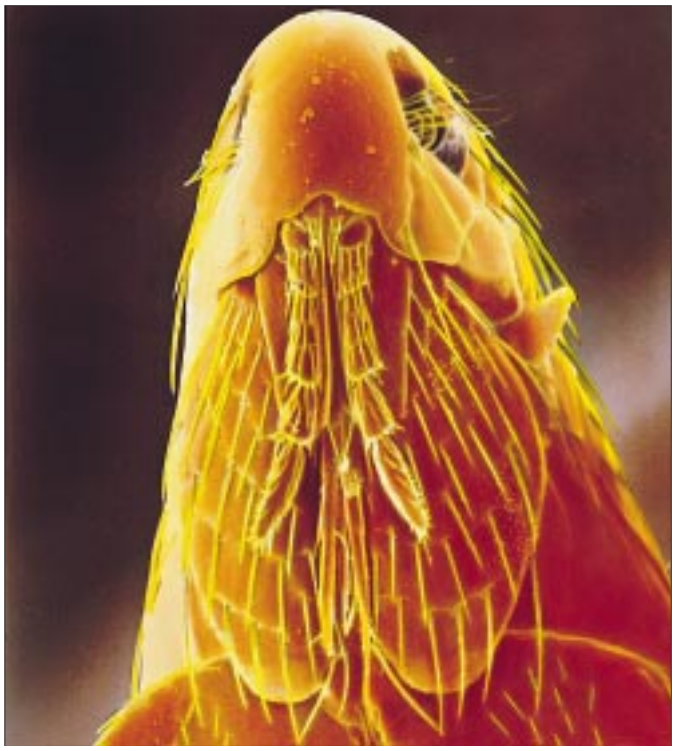
Although the patient recovered, the case is of clinical and public health importance as the strain of *Y pestis* when examined in the laboratory was found to be resistant to all first line antibiotics as well as to the principal alternative drugs for treatment and prophylaxis of plague *(New England Journal of Medicine* 1997;337:677-80). Although there are naturally occurring strains of tetracycline resistant *Y pestis*, drug resistance has not been a recognised problem in treating plague or other vector born bacterial diseases until now.

Dr Elizabeth Carniel, from the World Health Organisation Collaborating Centre for Yersinia at the Pasteur Institute in Paris, and her coauthors write: "The fact that the multidrug resistant plasmid was highly transferable in vitro to other strains of *Y pestis*, where it was stable, is of great concern. It is likely that this type of replicon can also be transferred among strains of *Y pestis* in their natural environment and, therefore, that resistance may spread locally in this species."

They added: "Even more alarming, the observation that *Y pestis* is able to acquire, under natural conditions, a resistance plasmid, regardless of its true origin, indicates that such a clinically ominous event may occur again."

Human plague is considered to be a re-emerging disease. From 1980 to 1994, 18 739 cases of plague occurred worldwide, and 1853 deaths were reported to the WHO by 24 countries in Africa, the Americas, and Asia. More cases were reported from 1990 to 1994 than in the previous decade. Outbreaks occurred in east African countries, Madagascar, Peru, and India. The outbreak in India in 1994 was particularly notable because no cases had been reported in humans there for nearly 30 years, and some of the cases were of the primary pneumonic variety.

Dr David Heymann, director of the division of emerging and other communicable diseases at the WHO, said: "The case is of concern as it is whenever resistance is detected in the laboratory. The problem is relating what happens in the lab to what is going on in the field."



DR TONY BRAIN/SPL

The rat flea plays a major role in the spread of *Yersinia pestis*

A spokesman for the public health laboratory service in London said: "The laboratory takes seriously any scientific evidence of growing multidrug resistance and encourages research into the genetic modification of current antibiotics to stay ahead in the fight against disease."

The prevention of plague in humans depends primarily on the maintenance of public sanitation and hygiene. Outbreaks of bubonic plague are controlled by reducing populations of vector fleas and their rodent hosts and by administering prophylactic antibiotics to people at high risk of exposure. Prompt and specific treatment reduces the case fatality from 60% or more to less than 15%. The drugs of choice for treatment are streptomycin or gentamicin, with the tetracyclines and chloramphenicol as highly effective alternatives. □

The discovery of multidrug resistance in a case of bubonic plague serves as a reminder that countries can never be allowed to become complacent about infectious diseases.

The WHO collaborating centres around the world with experience in plague have deteriorated in the past several decades. "Many industrialised countries, particularly in Europe, have lost funding for such collaborating centres," said Dr Heymann. "This deterioration is the result of false optimism, thinking that infectious diseases are no longer a problem."

David Dennis and James Hughes from the Centers for Disease Control and Prevention (in Colorado and Georgia, respectively) also warn against complacency in an accompanying editorial (*New England Journal of Medicine* 1997;337:702-4): "[This is] another grim reminder that emerging infectious diseases and antimicrobial resistance in one location can pose serious problems for the entire world." They add: "The threat from emerging infectious diseases is not to be taken lightly."

Plague has re-emerged throughout history. As is the case with other infectious diseases such as Ebola and yellow fever, this is a result of animals losing their natural habitat and coming into closer contact with humans to get food. Dr Heymann says that if the monitoring systems are in place then early signs can be spotted and action taken. The WHO is urging countries to put more money into such tracking and monitoring centres. Almost two years ago the organisation set up the division of emerging and communicable diseases surveillance and control to strengthen national and international surveillance of infectious diseases.

In brief

Cow to calf transmission of BSE is possible: A maternal cohort study of 301 calves strongly suggests a low level of transmission of the infectious agent of bovine spongiform encephalopathy from dams showing symptoms of the disease before or shortly after calving (*Journal of the Royal Statistical Society* 1997;46:299-349).

American smokers hit by price increase: This month saw the largest single increase in the price of cigarettes in American history as tobacco companies begin to feel the heat of compensation payouts. Wholesale prices have increased by an average of 7.6%, bringing the price of a pack of 20 cigarettes to $1.87 (£1.17).

Murder charge against Dutch nursing home dropped: The Dutch Public Prosecutors Office has dropped a murder charge against a nursing home. The charge had been made after the relatives of a patient with Alzheimer's disease alleged that staff were intentionally allowing him to dehydrate (9 August, p 327).

Mental health services discriminate against African and African Caribbean users: A report from the mental health charity Mind shows that African Caribbean and African people are more likely than other ethnic groups to be diagnosed as having schizophrenia, be detained in locked wards, and be treated with higher doses of drugs.

New influenza virus strain detected in humans: An influenza virus—type A (H5N1)—known previously to infect only birds, has been isolated in a 3 year old boy who died in Hong Kong last May of Reye's syndrome during an acute respiratory illness. The World Health Organisation said that this is the only case to have been detected so far in a human being.

US sets up research centres to protect children's health: The first United States federal research centres dedicated to protecting the health of children from environmental threat have been set up.

Manual workers more likely to be chronically ill

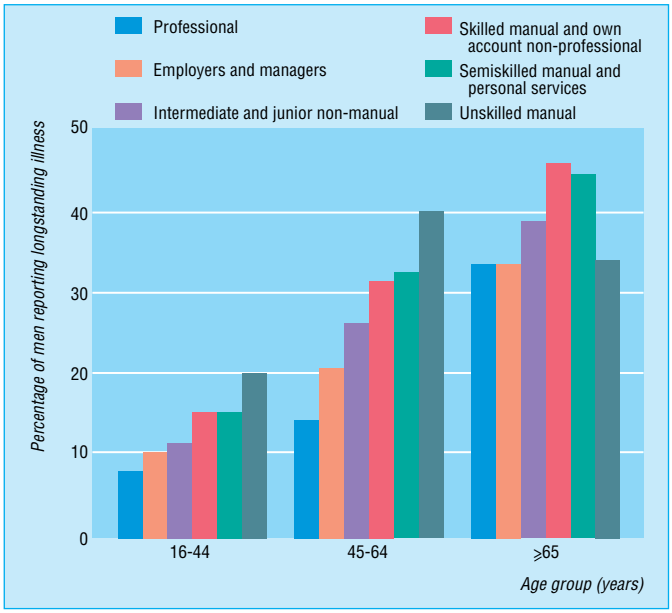
Jacqui Wise, *BMJ*

Manual workers in Britain tend not only to have shorter lives but also to have a greater risk of ill health and disability than non-manual workers, according to an analysis of health inequalities by the Office for National Statistics.

Men in manual occupations are about 40% more likely to report a limiting longstanding illness that restricts their activities than those in non-manual jobs (see figure). The difference among women is slightly smaller at 30%. For men and women aged under 65 years, the lower the socioeconomic group, the higher the prevalence of longstanding illness.

Although mortality has declined overall and also for most socioeconomic groups, the prevalence of self reported morbidity in the population has tended to increase over the past two decades, both overall, and for each socioeconomic group.

Health minister Tessa Jowell said: "No one pretends that these inequalities which have been entrenched over many years can be reversed overnight. To make a real difference we need long term policies." □



Relation between longstanding illness and socioeconomic group

Health Inequalities—Decennial Supplement is published by the Stationery Office, price £35.

The beginning of the end of the internal market

John Warden, *parliamentary correspondent, BMJ*

How the NHS will be reshaped under a Labour government began to emerge this week, with official guidance diluting the internal market created by the last Conservative government. Although the system of purchasers and providers remains, new priorities for next year's commissioning round for England place the emphasis on cooperation and transparency rather than competition.

Specific plans to replace the internal market await a forthcoming white paper, but 1998-9 is to be a transitional year in which the planning and delivery of health services reflect the emerging new agenda. *Priorities and Planning Guidance*, issued by the NHS Executive, aims to tackle concerns about the competitive market and lay foundations for "a new approach based on cooperation between all the players."

The guidance states that health authorities, GPs, and trusts will need to work together to build strong cooperative relationships. The four key principles are partnership, fairness, reducing bureaucracy, and improving financial management. Strategies and priorities will be developed through local discussions, to produce a "service and financial framework" by the end of November.

The parties are advised to adopt an open and transparent approach to sharing their financial position and prospects. Any material that would be made available to the board of one health service body should be open to others. Health authorities should consult widely with GPs and other key professionals to collate all commissioning intentions. They should provide a clear overview of the services planned for the local population, the resources available, and the priorities that will be followed if plans need to be modified.

Those involved are expected to work together constructively to share problems and reach agreement in partnership, with minimal recourse to arbitration. Ministers will take an active interest in any disputes that require arbitration.

The guidance states that the distribution of resources between fundholding and non-fundholding GPs needs to be seen to be fair. It has already been decided that from April both groups will work to a common waiting list. Further guidance on budget setting for fundholders will be issued soon.

From next year an increasing amount of the annual budget of each health authority should be committed through contracts covering at least three years. The division of resources between primary and secondary care has still to be decided, but the NHS planning director, Alasdair Liddell, warns that authorities and trusts will not be able to relax their approach to balancing their books.

The NHS Confederation highlighted the need for greater financial transparency within the NHS as well as full knowledge of the financial plans of social services and local councils. Without this, managers would be working in the dark, it said. □

"Quackery" outlawed in registered pharmacy

Duncan Campbell, *Edinburgh*

A serious loophole in Britain's medicines laws has been closed by the Royal Pharmaceutical Society after a disciplinary hearing in which a widely sold alternative therapy was described as unscientific "quackery."

The society's statutory committee last month warned registered pharmacists that they would be struck off if they associated themselves "in any way" with a remedy called "spagyrik therapy." Spagyrik therapy, sold by Signalysis of Stroud, Gloucestershire, is described as a "system of diagnosis and treatment in one" and has been marketed particularly at people with a life threatening or chronic illness. The process entails distilling then evaporating a blood and urine sample and examining the resulting ash under a microscope to produce "an individualised patient oriented diagnosis." The ash is then mixed with herbs, diluted, and posted back for oral administration to the patient.

The company operates through a large national network of "practitioners"—some of whom are registered medical doctors—who take samples and administer the remedies to patients.

At a series of hearings, the company claimed that its sale of spagyrik liquids as medicinal products was lawful without a product licence because they were produced at a registered pharmacy and under the supervision of a superintending pharmacist, Mrs Jacqueline Wells.

The committee found Mrs Wells guilty of serious professional misconduct which "renders her unfit to be on the register." However, she has been given until October to resign from the company, and if she does so she will face a reprimand instead.

The directors of Signalysis, Kenneth Spellman, a retired town planner, and Rosemary Spellman, who ran the service, were told that they were guilty of "misconduct" under the Medicines Act. Their premises would no longer be registered as a pharmacy. Had they been pharmacists they would have been struck off, the committee ruled. They had been "practising quackery from the premises of a licensed pharmacy."

The committee concluded that the "spagyrik treatment and therapy has no pharmacological basis at all." It added: "It is not supported by any clinical trials. It is not scientific. It has no credible or respectable place in scientific literature."

Signalysis had also claimed exemption under the Medicines Act because the company employs and uses medical doctors. Dr Alec Forbes, a registered medical practitioner and the former medical director of the Bristol Cancer Help Centre, was listed on stationery as the company's medical consultant. The committee did not further consider the position of registered doctors who prescribe spagyrik therapy or who act as advisers to the company.

The committee conceded that Mr and Mrs Spellman had "over the years responded to criticism and altered their presentation of the therapy." Although "their references suggest that they are well intentioned and compassionate people," what they had done was "reprehensible."

Mr and Mrs Spellman had originally claimed that "in all chronic illnesses regarded as incurable, spagyrik is able to offer help and the alleviation of pain" and that it had a "high success rate ... in practically all illnesses of humans."

These and similar claims were dismissed as "exceptionally dangerous nonsense" by Dr Charles Shepherd, a Gloucestershire GP who had provided most of the evidence which the committee considered. "If they could do any of that, they would be in line for the Nobel prize. I am very glad that the Royal Pharmaceutical Society shares my view on this quackery. I hope that the General Medical Council will now look at the role of registered medical practitioners in this affair." He added: "Spagyrik was clearly being aimed at very vulnerable patients, many of whom may not have had a precise diagnosis. They were being relieved of their savings rather than their suffering." □

FDA to have greater food regulation powers

Deborah Josefson, *San Francisco*

The Food and Drug Administration (FDA) in the United States is to have greater authority over the regulation of food under new legislation from the Department of Health and Human Services.

The proposed bill, the Food Safety Enforcement and Enhancement Act of 1997, authorises the FDA to recall foods deemed to be a public health hazard. The bill would also allow the administration to levy monetary penalties for food related violations of the Federal Food, Drug, and Cosmetic Act.

Although the United States's food supply is among the world's safest, millions of Americans a year are affected by foodborne illnesses. An estimated 9000 people, mostly young, elderly, or immunocompromised, die annually as a result. Recently several incidents of widespread foodborne illnesses have been well publicised—for example, in connection with hamburger meat infected with *Escherichia coli* and fruits and vegetables contaminated with cyclospora and the hepatitis virus.

Currently, the FDA cannot authorise the recall of food; the process is voluntary and dependent on the goodwill and cooperation of the food industry. If companies are uncooperative, all the administration can do is create negative publicity and seek a court order to seize food. Until now, enforcement options were limited to seeking court injunctions against unsafe or mislabelled foods—a process that is both costly and time consuming.

In January, President Bill Clinton announced a food safety initiative designed to overhaul the archaic food inspection system. A total of $43m (£27m) was budgeted for modernising food inspections, tracking foodborne illnesses, identifying emerging pathogens, and developing better microbial contaminant and containment methods. From this budget $24m was earmarked for the FDA. (See p 619.) □

DONNEZAN/RAPHO/NETWORK

The United States has been hit by a number of food scares recently

WHO criticised for ignoring drug dumping

Jacqui Wise, *BMJ*

The World Health Organisation has hit back at accusations that it is ignoring the problem of substandard drugs being dumped in the developing world.

Dr John Dunne, the former director of the WHO's division of drug management and policies, makes the allegation in an article in a new journal, *Drug Quarterly*, which he also edits (*Drug Quarterly* 1997;1(2):39-41). He says that the WHO has failed to react promptly to questions of impropriety in one of its offshoot publications, Market News Service (MNS). The MNS was set up by the WHO in 1992 to provide information on prices of drugs and raw materials for developing countries.

Dr Dunne said that many of the drugs listed by the MNS are of questionable provenance from unknown suppliers and that the publication makes no pretence at quality control. The task is left to buyers, who often cannot undertake adequate testing. He said that the WHO should be taking the lead in preventing unacceptable trading practices in supply lines instead of concentrating on promoting local production of essential drugs through the MNS. He added: "It is operating as a non-commercial broker promoting the supply of starting materials through unregulated middlemen to fledgling companies in developing countries."

Drug dumping, in which low quality drug ingredients are dumped on developing countries, is a recognised problem. One of the more tragic consequences of the practice was the disaster in Haiti last year when 70 children developed renal failure because of a lethal contaminant, diethylene glycol, in locally manufactured medicines. There have also been cases where drugs contain too little, or even none, of the labelled active ingredients.

Jonathan Quick, director of the WHO's action programme on essential drugs, said that he agrees with Dr Dunne that drug dumping and quality assurance are large problems that need to be tackled: "But Dr Dunne's article misunderstands and misrepresents the issues."

He said that the WHO had set up a working group in February to tackle the problems that he acknowledged existed within the MNS and that these were currently being worked on. But he emphasised that the MNS exists purely to provide information on prices and contacts about drugs for developing countries and does not guarantee the quality of the products. "We always could do more, but it is a question of resources."

The WHO has changed its work structure to increase the emphasis on quality, and since June there has been a full time coordinator of drug regulation and quality assurance capacity. "We are putting a big effort into working with governments to oversee good manufacturing practices," said Mr Quick. □

RON GILLING/PANOS PICTURES

Drugs in the developing world may contain too little, or even none, of the labelled active ingredients

Israel to set up genetic database after adoption scandal

Judy Siegel-Itzkovich, *Jerusalem*

Israel's parliament is to set up a genetic database to provide some scientific answers to a controversy that has been running for decades.

Blood and saliva samples will be taken from hundreds of families who claim that their babies and toddlers were taken from them during the early years of the state and handed over or even sold to childless Ashkenazi (of European origin) survivors of the holocaust. In addition, people who suspect that they were illicitly taken for adoption may undergo testing, and geneticists will try to match them with biological parents.

The issue has been simmering since the late 1940s and early 1950s, when tens of thousands of Jews emigrated to Israel from Yemen and were housed in primitive transit camps. It has been the subject of three official investigative committees—in 1967, 1988, and the current Cohen committee, headed by a retired justice from the Supreme Court, which has been hearing testimony for two years.

The latest wave of interest was triggered by the reunion of a woman with her biological mother. Tzila Levine, a 49 year old, dark skinned woman was raised on a kibbutz north of Haifa and moved to the United States in 1979. When her light skinned adoptive mother died five years ago, she asked for her adoption file but was told that it was lost. After watching the head of a Yemenite Jewish organisation speaking on American television, she contacted him and asked to undergo a genetic test. A geneticist from Hebrew University concluded with "99.9% certainty" that she was the daughter of Margalit Omessi, who claimed that her infant daughter had disappeared from a hospital soon after the family emigrated from Yemen to Israel.

The emotional headlines about their reunion led the Knesset's science and technology committee to set up a telephone hotline, which received calls from 470 individuals—most of them of Yemenite origin. They claimed that their children had been taken or were said to have died in hospital, but their bodies were never shown to them and they were told the funeral had already taken place. Some claimed that fake graves were built as a cover up for allegedly phoney adoptions.

The previous investigative committees had found no evidence for a "conspiracy" but had found that the (mostly Ashkenazi) immigration and medical authorities had frequently acted condescendingly to these immigrants from Muslim countries. Others blamed the throes of the war of independence for the lack of accurate records and for the burials of children who died of disease. The health ministry exhumed bones from 10 graves in a cemetery where Yemenite immigrant infants had supposedly been buried, but geneticists were unable to extract enough DNA for conclusive results. □

US to ban sale of many laxatives over the counter

Deborah Josefson, *San Francisco*

The Food and Drug Administration in the United States plans to ban the over the counter sale of medicines containing phenolphthalein, an ingredient in some popular laxatives.

The agency seeks to reclassify the ingredient as a category II constituent, an ingredient which is not generally recognised as safe and effective. The proposed ban, which is open to review for one month, would require medicines containing the ingredient to be withdrawn from the market or to be reformulated.

The move comes in the wake of several studies that showed that phenolphthalein increases the incidence of cancers in laboratory animals. A two year study conducted by the United States's national toxicology programme showed that rats and mice which were fed 50-100 times the human dose of phenolphthalein developed various tumours. Subsequent studies showed that phenolphthalein was capable of inhibiting the tumour suppressor gene p53 and that mice which were fed 30 times the human dose for six months developed lymphoma.

About a fifth of Americans use laxatives, over half of which contain the ingredient phenolphthalein. Anticipating the ban, many manufacturers of laxatives have already reformulated their products. Labels on laxatives generally warn that the products are designed for occasional and not long term use.

People with eating disorders and elderly people are those most likely to be chronic laxative users. Dr Robert Temple, a spokesman for the Food and Drug Administration, acknowledged that data do not exist to support the contention that phenolphthalein is a carcinogen in humans. He concluded, however, that its use is risky and said: "It's very hard to draw the line at which a laxative user could be at risk. The concern is for long term use, and it's greater the longer the use and the higher the dose people use. What we're saying is, find another laxative." □

Chemotherapy better tolerated when matched to body's rhythm

Zosia Kmietowicz, *London*

Giving chemotherapy as a variable infusion that mimics circadian rhythms rather than as a constant infusion reduces fivefold the adverse events in patients with colorectal cancer, according to the results of a randomised trial. The technique of variable drug infusion, known as chronotherapy, may benefit all patients with cancer requiring drug therapy by improving response and tolerance, believe French researchers.

In their trial the investigators assigned 186 patients with previously untreated metastases from colorectal cancer to receive chemotherapy of oxaliplatin, fluorouracil, and folinic acid either as a constant rate infusion or as chronotherapy using a portable, programmable pump (*Lancet* 1997;350:681-6).

They wanted to investigate the effect of delivering drugs to coincide with circadian rhythms, after certain processes crucial to cell division were seen in mice and human tissues either to speed up or to slow down at different times of the day or night. For example, the activity of an enzyme that breaks down fluorouracil, and therefore improves the tolerability of the drug, increases by 40% around midnight.

The results of the trial showed that matching the delivery of drugs to the body's activities had definite advantages. Chronotherapy reduced the rate of severe adverse effects on the lining of the gastrointestinal tract (for example, sloughing and inflammation) fivefold and halved the rate of functional nerve damage, such as loss of sensitivity in fingertips or feet.

Although treatment took longer to fail in patients receiving chronotherapy than in those receiving a constant infusion (6.4 months *v* 4.9 months), the three year survival times were similar in both groups.

Professor Karol Sikora, deputy director of clinical research at the Imperial Cancer Research Fund and professor of clinical oncology at Hammersmith Hospital in London, commented that, although chronotherapy obviously had some benefits, these were too small to warrant the use of the technique routinely.

"Chronotherapy is expensive, complicated to give, and very labour intensive. If we are devoting resources to this then they are being taken away from other parts of our work with cancer patients," he said. "It may be worth while using chronotherapy if we could identify which patients could benefit the most in terms of an improved response." □

STEVE GRAND/SPL

Chronotherapy may reduce the rate of severe adverse effects

HIV home test kit banned in Germany

Helmut L Karcher, *Munich*

German health authorities have banned the sale of a do it yourself AIDS testing kit that was due to go on sale in pharmacies this month.

The "No-HIV logic" testing kit was developed by the Canadian biotechnology company Pace. Germany would have been the only country in the world where a home testing kit was available.

AIDS experts have long debated the advantages of home testing kits. At the AIDS world congress in Vancouver last year, a special working group supported the idea because home sampling could encourage testing among those at high risk who may not want to seek the help of a doctor.

In 1996 the Food and Drug Administration in the United States licensed a test kit that instructed patients how to collect a blood sample and where to send it for evaluation. Counselling was provided via an anonymous telephone hotline. The American producer, Johnson and Johnson, however, has stopped producing the kit because only 90 000 had been sold within a year.

This new testing kit differs in that it allows users to test themselves for HIV. The procedure looks somewhat complicated, but it is said to take no more than two minutes. A study at the University of Saarland in Saarbrücken showed that test results with the kit from 241 blood samples were reliable and fully consistent with those from enzyme linked immunosorbent assays (ELISAs) or western blot tests.

Nevertheless, much concern has been expressed in Germany about the availability of such kits. The German National AIDS Council asked the government not to allow the sale of these kits to private users. They argued that if users got a false negative result they could believe themselves "falsely safe." Alternatively a positive result could make them suicidal without the backup of medical and psychological help. □

Meet Ms Managed Care

Managed care in the United States is under attack from politicians, the press, doctors, and the public. **Karen Ignagni** tells David Woods how she is trying to improve its image

Karen Ignagni sees herself as a consensus builder

Karen Ignagni heads an organisation that is one of the most visible and vulnerable in Washington—visible because it represents about a thousand managed care companies, and vulnerable because managed care is under constant attack from politicians and the media.

Managed care is a system of fixed prepayment for comprehensive healthcare coverage in which the companies providing it control costs by curbing use. Another definition is that it is the application of standard business practices to the delivery of health care in the best—or, depending on your point of view, the worst—traditions of untrammelled American free enterprise. More than 140 million Americans are now covered by some kind of managed care arrangement.

Karen Ignagni might reasonably lay claim to the title Ms Managed Care. As executive director of the American Association of Health Plans (AAHP), she handles both the high profile and the low esteem of her industry with grace and diplomacy. During the summer she spoke to a group of a hundred or so academic doctors at Philadelphia's Thomas Jefferson University Hospital—a segment of the medical profession especially opposed to managed care because it sees the system as being uninterested in research and tertiary care. Acknowledging that managed care sceptics abound "in government, in academe, in board rooms, and in the health professions," she said that she and her organisation are in the firing line day and night.

"Reporting on complex matters surrounding managed care gets moulded into convenient, and sometimes confusing, soundbites"

The answer, she said, is in learning how to make the transition from overuse of services to underuse. That requires listening: listening to doctors telling her that they have too much paperwork and then moving to standardise the forms for registering their education, training, hospital affiliations, specialty, board certification, work history, malpractice claims, and other information; or listening to patients saying that they don't have enough choice and then developing a "patient's right to know" programme. Beyond that, she says, having a sense of humour and not taking herself too seriously is how she gets through the day.

Ms Ignagni might not have won over her academic audience to the wonders of managed care, but it was clear that they were far more receptive after her articulate and reassuring presentation. And the industry she represents is enthusiastic about her stewardship. Steven Wiggins, founder and chairman of one of the more innovative managed care companies, Oxford Health Plans, said that AAHP had never been more effective. He credits Ms Ignagni for much of this change.

At AAHP she oversees a staff of 100 and an annual budget of $20m (£12.5m). The association's main activities are lobbying, policy development, research, educational conferences—and public relations. It is this last that is by far the most challenging. While surveys repeatedly show Americans to be generally in favour of the trend towards managed care, isolated instances of morbidity and mortality have led to media horror stories and to trigger happy legislation. Before they adjourned for their summer break, legislatures in 37 states had passed 182 laws regulating managed care.

Karen Ignagni is especially troubled by the controversy over "drive through deliveries." Managed care had cut the hospital time for normal deliveries from 3.9 days to 2.1 days—a reduction that might have been ascribed to improved management of patients. Yet 26 states and the federal government have enacted laws requiring a minimum 48 hour stay. She is concerned that debate on the issue was reduced to a discussion of the number of hospital days rather than to the optimum prepartum and postpartum care—in other words, to best practice. And she is convinced that media reporting on complex matters surrounding managed care gets moulded into convenient, and sometimes confusing, soundbites.

With a few notable exceptions, the public relations stance of the individual managed care companies is appalling. They react to media criticism and do little to tell the story of their achievements. Travelling 40% of her working time, Karen Ignagni is a one person antidote to the companies' poor image. And the association is working with individual companies to help them to be less defensive, more willing to convey facts to the public, more open and proactive. AAHP regularly invites the Washington press corps to its offices for briefings.

But it's a struggle. One of the AAHP's largest members, Aetna/US Health Care, recently withdrew from the association, taking with it its $800 000 annual membership fee. While there was press speculation that the move might have been precipitated by dissatisfaction with the AAHP's public relations efforts, Ms Ignagni cites other reasons, such as Aetna's disappointment that many member plans were unwilling or unready to contribute to the association's ambitious research proposals. She expresses the hope that Aetna will return to the fold, together with Cigna, another large company that left in 1995.

Yet she sees a strategic shift at the American Medical Association (AMA), which for a long time resisted the move to managed care. Her association is now actively collaborating with the AMA in such areas as developing treatment guidelines, and 20% of members are doctor owned practices.

Ms Ignagni is a native of Rhode Island and has an MBA from Loyola College in Baltimore. Before coming to AAHP four years ago, she was director of employee benefits for the American Federation of Labour Congress of Industrial Organisations, and before that she served as a member of the Senate Labour Committee and as assistant director of the Committee for National Health Insurance. How does that background square with representing the very essence of free enterprise, market driven medicine? "I'm a consensus builder," she says. "I like to think outside the box." □