Complementary medicine is booming worldwide

Complementary medicine is gaining in popularity worldwide, with increases in the number of practitioners and the number of patients consulting them. As a result the amount of public and private money spent in this sector is also rising. Yet there are wide variations among countries in the degree of legal recognition such treatments enjoy and the ways in which they are practised. The Treaty on European Union guarantees free movement of Europe's citizens and the right of individuals to work in other member states, but, whereas doctors can now move more freely between member countries, no such freedom exists for most complementary practitioners. A discipline recognised in one country, such as chiropractic in Britain, may be proscribed in another, such as France.

ANITA CORBIN/IMPACT

Norway's doctors regard homoeopathy as "the old arch enemy"; French doctors are taught it at medical school

Britain

One in 10 people in Britain consults a practitioner of complementary medicine each year, says a recent survey by the Research Council for Complementary Medicine. Of the 160 different treatments counted by the council, however, just six account for three quarters of those used. The most popular branches are acupuncture, chiropractic, osteopathy, homoeopathy, herbal medicine, and hypnotherapy.

A survey conducted by the National Association of Health Authorities and Trusts showed that £1m ($1.5m) of public money was spent on purchasing complementary treatments in 1993. This figure is a gross underestimate by the association's own admission, reflecting less than half of health districts and counting only formal contractual arrangements. In reality much complementary medicine is practised by general practitioners and practice nurses within their own surgeries. Private money is spent in even greater amounts on non-conventional medicine, with research from the University of Sheffield suggesting that 10-12 million visits a year are made to complementary therapists at a cost of £15-£40 per consultation.

Regulation has been minimal in Britain, and therapists practise freely under common law. Some groups, such as homoeopaths and acupuncturists, have voluntary self regulation, but often several organisations represent a single discipline. Homoeopaths, for example, have a Faculty of Homoeopathy, whose members are medically qualified, and a Society of Homoeopathy, whose members are not. Osteopathy and chiropractic have seen the greatest changes. Both have recently achieved statutory regulation, ratified by an act of parliament. The Osteopathy Act 1993 led to the setting up of the General Osteopathic Council. This regulatory body, analogous to the General Medical Council, will be responsible for all aspects of professional regulation including ethics, disciplinary structures, and insurance regulations. The council will open a formal register of practitioners later this month, and the General Chiropractic Council hopes to follow suit within two years. The move was welcomed by Brian Daniels of the Osteopathic Information Service. "At the moment, anyone can call himself or herself an osteopath," he said. "This move will protect first and foremost patients but also bona fide practitioners from the charlatans."

Research into complementary medicine has been patchy. According to Dr Tony Peatfield of the Medical Research Council, many funding applications received by the council in this subject are of poor scientific quality. Dr Andrew Vickers of the Research Council for Complementary Medicine believes this is partly to do with a lack of infrastructure. "Almost all research into complementary medicine has been done by doctors," he said, "because doctors have infrastructure they take for granted, such as offices, computers, and secretarial support." The attitudes of therapists themselves have also been a barrier, he believes, with a failure to recognise the need for evidence of the efficacy of treatments owing to a lack of scientific education and research skills. A new funding body, the Foundation for Integrated Medicine, now funds research into conditions such as the irritable bowel syndrome, hypertension, menopausal symptoms, and back pain. The Cochrane Collaboration, an organisation that collates high quality evidence in all areas of clinical research, has recently set up a field for complementary medicine within its database.

Training in complementary treatments is becoming more academic. Many courses—for example, in chiropractic, osteopathy, acupuncture, and herbal medicine—are now university based and lead to a bachelor of science degree. The universities of Exeter and Southampton both have departments of complementary medicine and offer postgraduate qualifications.

As research and education in complementary medicine become stronger, the medical establishment has revised its attitude. The BMA's 1993 report on the subject showed a cooperative approach, acknowledging that many patients seek non-conventional treatments and supporting moves towards regulation and research within some branches of complementary medicine.—SANDRA GOLDBECK-WOOD, *BMJ*

France

In France more than a third of people use some form of *médecine différente* (alternative medicine) or *médecine douce* (gentle medicine), says a recent survey. The most popular forms are homoeopathy, acupuncture, phytotherapy, thermalism, osteopathy, and chiropractic.

Homoeopathy, the leading branch, is practised predominantly by doctors and in some public hospitals. The 10000 or so doctors who use homoeopathy have studied it during their medical training, which is funded by the state.

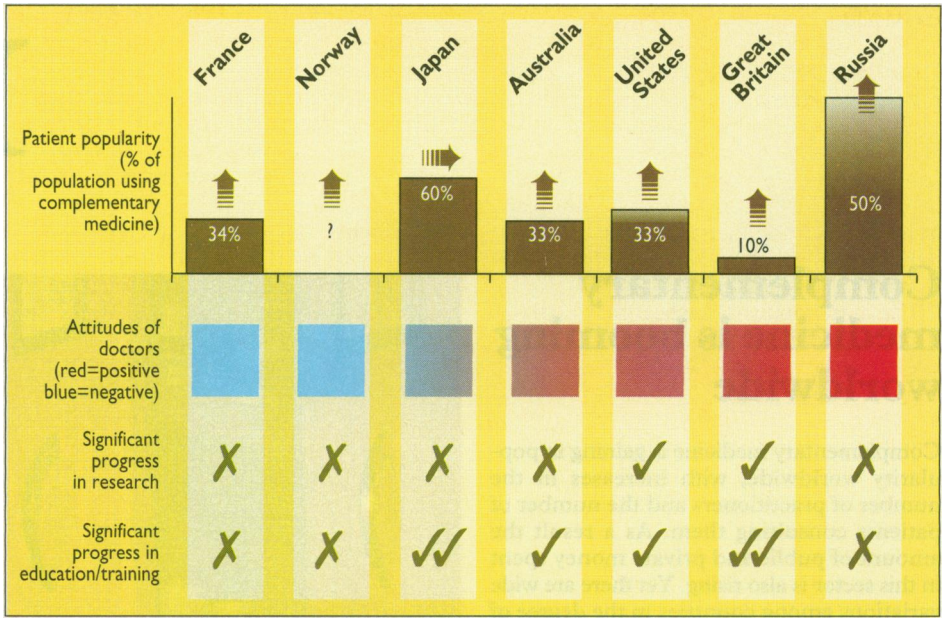
The Academy of Medicine is sceptical about the value of homoeopathy, yet it remains popular and supports successful homoeopathic pharmaceutical companies such as Boiron and Dolisos. Acupuncture, phytotherapy, auriculotherapy, and aromatherapy are also widely practised by doctors, and acupuncture is taught in some medical faculties. Some of these treatments are also practised, illegally, by self appointed healers.

France, like Germany, is a country of spas, with their associated discipline of thermalism. These treatments are largely prescribed by doctors, who select spas specific to rheumatological, respiratory, cardiovascular, urinary, renal, or digestive diseases. In some cases spa treatment is partly reimbursed by health insurance.

Around 200 doctors have some training in chiropractic. In fact, it is illegal for anyone other than a doctor to practise chiropractic, despite the existence of the French Institute of Chiropractic in Paris. In reality, however, non-medical chiropractors are usually tolerated as independent professionals, with osteopaths enjoying a similar status.

Both complementary and conventional consultations are paid for by the patient, but whereas conventional interventions are fully reimbursed by insurance, non-conventional treatments and medicines are only partly reimbursed. Research into complementary treatments is sparse and disorganised.

Despite an apparent resurgence of popular interest in complementary medicine, French doctors remain sceptical. French cardiac surgeon Christian Cabrol summarised medical opinion thus: "It is better to train good doctors and educate the public than to give in to the irrational and generate extra expense. Would you climb into a plane piloted by a non-professional?" —ALEXANDER DOROZYNSKI, *medical journalist, Paris*



Attitudes of doctors to complementary medicine differ from those of the public across many countries

Norway

By far the most widely practised complementary therapy in Norway is homoeopathy, followed by acupuncture and aromatherapy. Other therapies are relatively uncommon.

As in Britain, complementary medicine is completely deregulated and can be practised by anyone. Homoeopaths have their own voluntary regulatory organisation, the Union of Norwegian Homoeopaths, which runs private training courses leading to a diploma. Some homoeopathic practitioners are also medical doctors, as in France and Britain, but unlike in France, training in homeopathy is entirely private and self-financed.

Consultations with an alternative therapist are self funded, as are general practice consultations. Hospitals, which are state funded, offer only conventional medicine.

Research into complementary medicine is limited to studies conducted by individual companies on their own products. There is no state funding available for research in this area.

The Norwegian government has been reluctant to embrace complementary medicine, offering little or no funding for treatments, training, or reasearch. However, a new piece of legislation was introduced this year, which legitimates a new category of health care products, termed "natural medicinal products." These would previously have been registered either as commercial or as medicinal products. This brings the Norwegian authorities into line with most other European countries, and protects against misleading advertising. Natural medicinal products may now not be promoted as a definite cure for any particular illness. Only five products have been accepted under the new regulations to date, which are remedies for colds, insomnia, and poor circulation.

Attitudes to non-conventional medicine diverge widely; while public demand appears to be rising, doctors remain hostile. Some refer to homoeopathy as "the old arch enemy." The Norwegian Medical Association is soon to publish a report outlining its view of complementary medicine. Dr Jon Nessa, chairman of the committee of doctor homoeopaths and conventional doctors who are producing the report, refuses to accept complementary practices. "I am critical of the entire way these people think, because it is naive," he said. "Complementary medicine is a foolish concept, because it embraces everything, from praying for your neighbour to acupuncture. The medical profession can never relate to it. Theoretical and complementary medicine are mutually exclusive ways of thinking."—LEIV GUNNAR LIE, *medical correspondent, Norway*

Japan

In Japan the distinction between Western and complementary medicine is blurred, with two thirds of Tokyo's inhabitants claiming to use non-conventional treatments. This is partly related to the widespread practice of traditional Japanese medicine, introduced some 1000 years ago from China. Western medicine, by contrast, has only been practised in Japan for around 200 years.

The leading alternative treatments in Japan are herbal medicine, acupuncture, and acupressure (or shiatsu). In 1992 a national statutory licence was introduced for acupuncture and acupressure, which were previously regulated on an ad hoc, regional basis. The powerful status of herbal medicine is reflected in the 600 or more herbal treatments available under the public health insurance system. These form 2.9% of the total drug budget and are freely available at pharmacies with or without a doctor's prescription.

Acupuncture and acupressure are not refundable under public health insurance. Despite this they remain popular enough to support a total of around 95 000 acupressurists and 65 000 acupuncturists across Japan.

Education in complementary medicine varies strikingly among the disciplines. Whereas traditional Japanese medicine is predominantly a postgraduate qualification for trained doctors, acupuncture and acupressure are non-medical degree courses. Osteopathy, chiropractic, yoga, and a few other treatments have no state recognised training at all, and anyone may practise them.

Despite the popularity of non-Western medicine, doctors remain generally critical of non-scientific approaches.—MASAYA YAMAUCHI, *science reporter, Japan*

Australia

In Australia a third of the population regularly visits a natural therapist and two thirds regularly take vitamins and other "natural" treatments, says a recent survey from the University of Adelaide and the South Australian Health Commission. The study showed that Australians spend more than £451m ($677m) a year on alternative medicines and treatments.

The most popular branches are chiropractic, acupuncture, naturopathy, massage, herbal medicine, and homoeopathy, but many other treatments are widespread, such as traditional Chinese medicine, reflexology, iridology, and aromatherapy. The Adelaide survey showed that women were more likely than men to use alternative treatments, while another study suggested that women who had received tertiary education were more likely to use complementary medicine than those who had not.

Regulation of non-conventional medicine is organised along regional lines, but state to state variations are small. Much greater are the variations among treatments. In Victoria, for example, acupuncture is a four year university based degree course and chiropractors and osteopaths are formally registered with the Chiropractors' and Osteopaths' Registration Board of Victoria; aromatherapy, iridology, reflexology, and homoeopathy, meanwhile, may be practised by anyone. Several universities now offer bachelor degrees in natural therapies as well as government accredited courses, and some of these courses attract education grants.

Complementary treatments are not generally covered by the compulsory federal medical insurance service, Medicare. The exceptions are medically trained general practitioners performing certain treatments, such as acupuncture, in their own surgeries. Private health funds, on the other hand, are beginning to cover selected treatments such as chiropractic and osteopathy, acupuncture, and physiotherapy, and one Sydney private hospital has purchased a "wellness programme" to offer its patients Swedish and shiatsu massage and yoga classes.

Research into complementary treatments in Australia is largely funded by manufacturers of "alternative" products, and medical attitudes remain correspondingly cautious. The Australian Medical Association president, Dr Keith Woolard, said: "We're not out to stop anyone investing their money in going to a chiropractor or naturopath, or whatever, as long as they're safe, but we certainly don't think there should be any government funding for such therapies until there's clear and strong evidence of benefit."—CHRISTOPHER ZINN, *Australian correspondent, Guardian*

United States

In the United States alternative medicine has traditionally attracted scorn from the medical establishment. Any physician expressing an interest in unconventional medicine risked censure by his or her peers. Yet in 1991, one in three Americans visited an alternative health practitioner, spending an unreimbursed $13.7bn (£9.1bn) dollars for their services. The number of consultations with alternative practitioners exceeded the number of consultations with primary care physicians, according to one estimate, although 80% of people using alternative treatments also sought conventional medical advice.

By 1994 the picture had changed, with a study suggesting that as many as 60% of physicians had at some stage referred patients for complementary care and that over half of patients with cancer were receiving alternative treatments. This trend has been reflected in the insurance industry: in 1992 the America Western Life Insurance Company for the first time offered a plan covering complementary treatments. Indeed, several state legislatures are drafting laws requiring insurance companies to cover some alternative treatments.

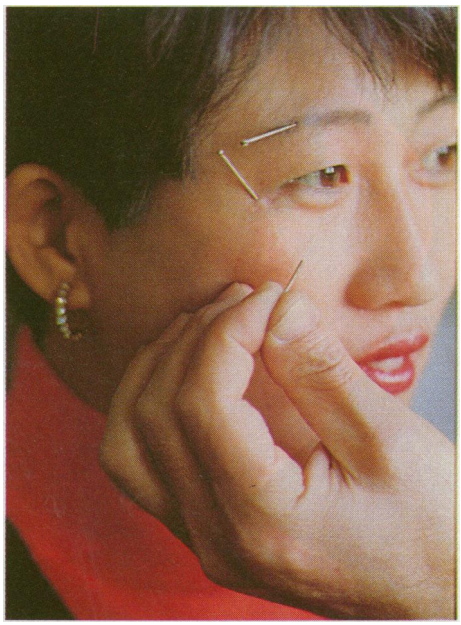
The commonest forms of non-conventional treatments are chiropractic, acupuncture, vitamin and herbal treatments, homoeopathy, biofeedback, massage, hypnotherapy, and yoga. The full range is far broader and extends to more esoteric forms, such as magnetism therapy and shamanism.

Although osteopaths, like doctors, require university degrees supplemented by hospital residencies and further specialist licensing qualifications in order to practice, the regulations and licensing of other treatments varies widely. All states license chiropractors, and some states also license acupuncturists, homoeopaths, and practitioners of traditional Chinese medicine. The training of alternative practitioners varies from those who have medical degrees to those who merely proclaim expertise.

Regulation of alternative drug treatments is equally loose. Conventional medicines undergo rigorous scientific trials before being approved by the Food and Drug Administration. Yet under the Dietary Supplement Health and Education Act 1994 alternative medicines marketed as foods or dietary supplements are exempt from strict pharmaceutical regulation as long as no medicinal claims are present on the product label.

Growing demand for complementary treatments has led to growing interest in research. In 1991 the US Senate set up the Office of Alternative Medicine at the National Institutes of Health. With a budget of $5.4m (£3.6m) to facilitate evaluation of alternative treatments, it has funded studies to evaluate bee pollen as a treatment for asthma, shark cartilage as an anticancer agent, and an amino acid claimed to shrink brain tumours. The office also offers courses in research methods to help practitioners of complementary medicine to set up scientifically valid trials.

Because of the increasing prevalence of alternative care, a government panel recently recommended that the traditional medical school curriculum be amended to include mandatory course work on complementary treatments. Currently, 40 medical schools, including Harvard, Stanford, and Johns Hopkins Universities, offer the subject. —DEBORAH JOSEFSON, *doctor journalist, Baltimore*



DING/NOUVELLE/GAMMA/FSP

Japan's 65 000 acupuncturists are statutorily regulated

Russia

Alternative medicine was first officially recognised in Russia in 1993, after which it became legal to teach and practise it. Yet traditional folk remedies had always been common in the former Soviet Union. Western medicines were expensive and often inaccessible. Most rural Russians still collect herbs and grasses and brew their own remedies for common ailments. Many even view Western medicine with suspicion, exposure to poorly trained doctors and irregular supplies often confirming people's lack of faith in its efficacy.

After a congress of alternative practitioners in May 1996 the Russian Ministry of Health officially recognised the eight most popular branches of complementary medicine. These include reflexology, chiropractic, massage, homoeopathy, and a peculiarly Russian therapy—the Buteiko breathing method. Along with official recognition goes an obligation to adhere to guidelines. Practitioners must be medically trained in order to practise some disciplines, such as acupuncture and those that entail manipulation, while for others the requirement is only that they be "medically literate." In theory all must have a licence to practise, and this is given after completion of a state recognised course and diploma. In practice this regulation is not enforced, and newspapers often carry advertisements by practitioners with doubtful qualifications.

All training and research into alternative medicine is privately financed. For example, the All Russian Scientific and Research Institute of Traditional Medicine, Moscow's main body representing alternative medicine, finances its research by running courses. Training in complementary treatments is expensive, often costing the average monthly wage for just a six week course.

Unlike in France and Norway, there is little opposition among the medical establishment to complementary treatments. —MIRANDA INGRAM, *Moscow correspondent, European*

Headlines

Mental health services close to collapse: The Royal College of Psychiatrists has passed an emergency resolution calling for an end to bed closures and for more 24 hour nursing care centres where patients recovering from the acute phase of their illness can go, rather than being discharged into the community. At its annual conference in London last week, the college warned that mental health services for severely disturbed people are on the point of collapse.

Anabolic steroids to become controlled drugs: Anabolic and androgenic steroids, which are liable to be misused by athletes and bodybuilders, are to be classed as controlled drugs in Britain from 1 September. Clenbuterol and five growth hormones will also come under the Control of the Misuse of Drugs Act.

Chiropractic bill is vetoed by New York's governor: Citing the concerns of business groups over added costs, New York's governor, George Pataki, vetoed the bill that would have required health insurance companies to pay for unlimited chiropractic services (8 June, p 1441).

Second measles, mumps, and rubella vaccine is introduced: From 1 October children in the United Kingdom are to be offered a preschool booster of the measles, mumps, and rubella vaccine (MMR), which will be given at the same time as the diphtheria, tetanus, and polio booster. The aim is to increase protection given by the first MMR vaccine, which is routinely offered at 12 to 15 months. A measles epidemic was predicted last year, but this was successfully averted by an extra immunisation campaign during the winter of 1994.

African HIV trial starts: A trial looking at the prevention of mother to child transmission of HIV infection has started in Africa, where breast feeding is the norm. The perinatal transmission study will involve 1900 HIV positive women in five sites in South Africa, Tanzania, and Uganda and will use a combination of zidovudine and lamivudine.

Parents of autistic children experience delays in diagnosis: A report by the National Autistic Society shows low levels of professional awareness of the condition. The report, backed by the Department of Health, shows that half of parents of autistic children had experienced difficulty in obtaining a diagnosis.

Back up drug found for severe malaria

Artemether, the active ingredient of a traditional Chinese remedy for fever, is as effective as quinine in severe malaria and could become increasingly important if quinine resistance spreads, researchers say.

Plasmodium falciparum is gradually becoming more resistant to quinine in Asia, and in many places there may soon be no adequate treatment for severe malaria. Most worrying is the possibility of resistance spreading to Africa, where most deaths from malaria occur. Artemether, derived from the wormwood plant, is more easily administered than quinine. It is the principal active component of the traditional Chinese remedy qinghaosu, used for thousands of years as a cure for fever and widely available in south east Asia.

Two randomised studies carried out in the Gambia and Vietnam with different drug regimens and study populations produced similar results (*New England Journal of Medicine* 1996:335:69-75, 76-83) Both showed that the clearance of parasites was significantly more rapid in the patients given artemether, although the drug did not prove significantly better than quinine in reducing mortality.

In the Vietnamese double blind study of 560 patients over 15 years old with severe malaria of various kinds, deaths were 13% in the artemether group compared with 17% in the quinine group. In the Gambian unblinded study of 576 children, all of whom had cerebral malaria, the case fatality rates were 21% in the artemether group and 22% in the quinine group.

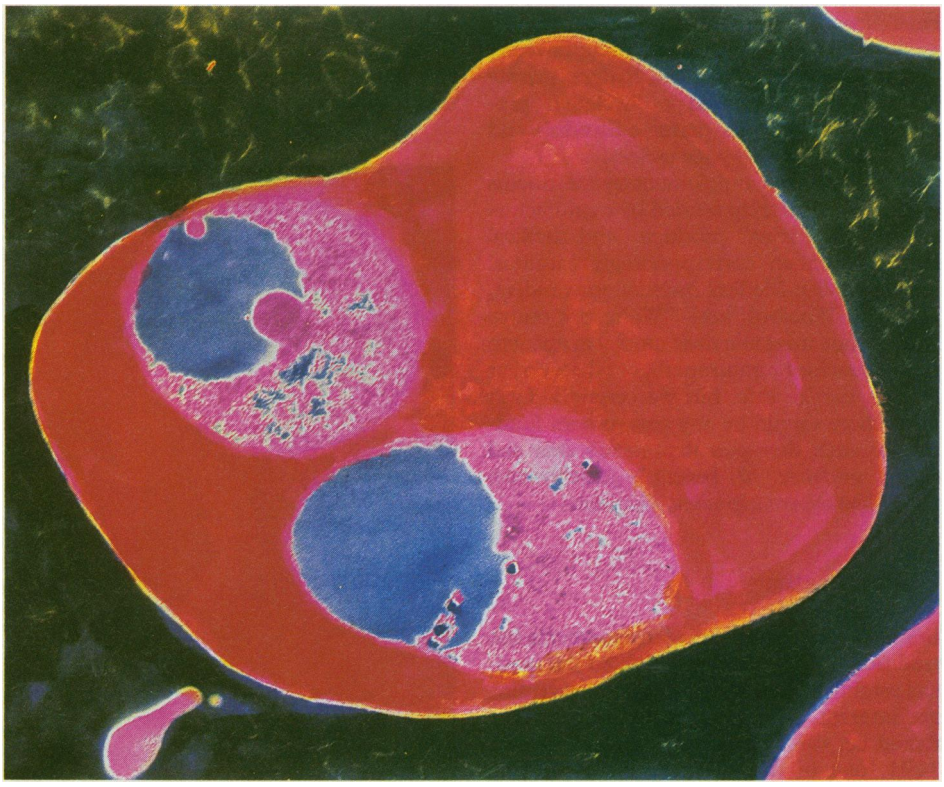
Expected side effects such as abscesses and hypoglycaemia were seen with quinine. In the artemether group the length of time to recovery from coma was prolonged, but there was no increase in neurological sequelae.

Because of quinine's potential toxicity it is ideally given by carefully controlled intravenous infusion—which is often impractical in rural health clinics. The World Health Organisation recommends administration by the intramuscular route, but this tends to induce irritation and occasionally abscess formation. Much less skin irritation is seen with artemether administered intramuscularly, and it can also be given orally or even as a suppository.

Dr Dominic Kwiatkowski, coauthor of the Gambian study and senior clinical fellow at Oxford University, said: "It is a big worry that there is only one standard therapy for severe malaria, especially as quinine resistance is starting to be seen. Once you get a pocket of resistance it doesn't take long for it to spread and it will be worldwide eventually. Malaria is a huge problem worldwide and artemether would be much more practical to administer than quinine."

He added: "These trial results have massive implications. It is difficult to know whether to have the drug used widely now and risk resistance to it developing or keep it in reserve until quinine resistance becomes widespread."

Dr Peter Trigg, a scientist in the malaria unit for the World Health Organisation, said: "Artemether is recommended in Thailand and the borders where there is multiple resistance. Although we appreciate it has operational advantages in the field, we do not recommend its introduction into Africa because of fears that it would be widely used and resistance would spread. There is concern that this drug is really the last in the line."—JACQUI WISE, *BMJ*



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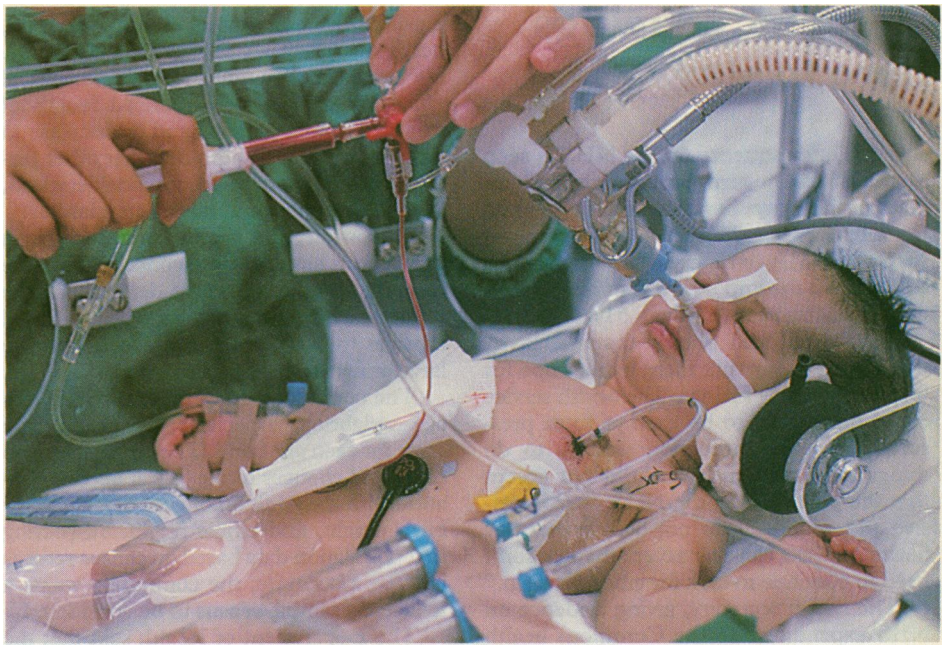
Plasmodium falciparum is gradually becoming resistant to quinine in Asia

Extracorporeal membrane oxygenation saves lives



PETER RYAN/SCIENCE PHOTO LIBRARY

Extracorporeal membrane oxygenation could save more babies' lives than traditional care

The lives of severely ill newborn babies can be saved by a technique for providing life support outside the body, known as extracorporeal membrane oxygenation (ECMO), say British researchers.

The UK Collaborative ECMO Trial Group estimate that the technique, in which blood is pumped through an oxygenator and returned to the body, could save up to 200 babies at high risk of death from respiratory failure annually in the United Kingdom. This is "equivalent to one extra survivor for every three or four infants allocated ECMO," the trialists claim.

The latest research, published in the *Lancet* (1996;**348**:75-82), included 185 infants recruited from 55 British hospitals who were randomly assigned conventional care or transfer to one of the UK's five centres specialising in the technique. Researchers found that only 30 of the 93 infants allocated extracorporeal membrane oxygenation (32%) died, compared with 54 of the 92 allocated conventional care (59%). The difference in survival applied irrespective of the primary diagnosis, disease severity, and type of referral centre. No corresponding increase in the incidence of severe disability was found at one year.

"ECMO is clearly now an option to be actively considered before these babies become moribund," said researcher Dr Diana Elbourne, director of the perinatal trials service at Oxford's Radcliffe Hospital

The technique has been widely used in the United States since 1976, but definitive clinical trial results have been lacking until now.

"You could say that the US acted rashly without the data, yet have been proved right—up to 2000 babies' lives have been saved since its introduction in the US—whereas the UK held back until they had the evidence to satisfy their peers," said Roger Stoll, professor of paediatrics at the University of Vermont.

But Professor Stoll said less invasive, cheaper treatments such as nitric oxide, high frequency oscillation, and natural surfactant extracts may prove superior to extracorporeal membrane oxygenation, which costs around £50 000 ($75 000) per machine.—ALISON BOULTON, *medical journalist, London*

New system will fail more GP registrars

More registrars in general practice will be refused certificates of competence when summative assessment is introduced throughout the United Kingdom on 1 September, a study of the process has shown.

Results of a three year pilot study in the west of Scotland reported in the *British Journal of General Practice* (1996;**46**:411-4) estimate that an average of 5% of general practice registrars a year will not receive their certificates. Nearly all the registrars who were judged incompetent in the pilot scheme were picked up by video assessment—one of the most controversial elements of the new examination system.

The leader of the study, Professor Stuart Murray, professor of general practice at the department of postgraduate education at the University of Glasgow, believes that the results show that the summative assessment process works as it picked up a number of trainees who were not competent to enter general practice. Under the current system, only 0.2% of general practice registrars fail to get their certificates of satisfactory completion.

The study evaluated an audit project, trainer's report, and a multiple choice paper plus videotaped consultation for 359 general practice registrars completing their training between 31 July 1993 and 31 July 1995. Seven trainees were refused a certificate, four of whom had been deemed acceptable by their trainers. A further 10 might have been refused if the process had been mandatory.

One concern highlighted by Professor Murray in the study was the lack of objectivity displayed by trainers. The paper states: "The unshakeable belief of some trainers that their trainee was competent, despite evidence to the contrary, was striking." He added: "I think trainers' judgements are based on some of the cuddly things. The trainer has been the mentor of the trainee for a long time, and it is much harder to be critical."

The Joint Committee for Postgraduate Training will take on a more active role for issuing certificates of satisfactory completion under the new system. A general practice registrar who fails one element of the examination process or who the trainer has expressed concern about will then be finally judged by a national panel.

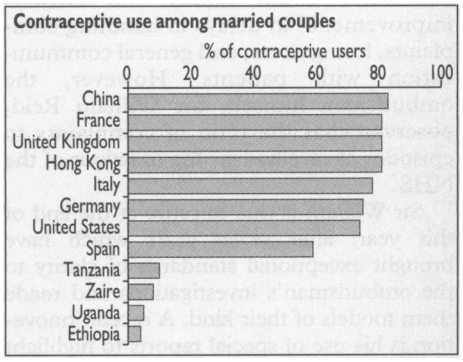
Professor Murray says that the new system has considerable resource implications. For the video component, which is the most resource intensive part of the process, two hours of assessor time per registrar is needed for initial assessment. The national panel would look at 10% of trainee videotapes.

Dr Laurence Buckman, chairman of the General Medical Services Committee's education subcommittee, said that he remains to be convinced that the process will work. He said: "It is very difficult to judge competence, and we do not know who these 5% of registrars will be."—JACKIE CRESSWELL, *freelance journalist, London*

China is top of contraception league

The United Kingdom, France, and Hong Kong are second only to China in the use of contraception, with more than 80% of married couples using some form.

There are 16 countries in Africa where less than 10% of the population uses modern contraception according to the league tables of 98 countries drawn up by the family planning charity Marie Stopes International. Worldwide, the most popular form of contraception is female sterilisation, with the contraceptive pill most commonly used in Europe.—JACQUI WISE, *BMJ*



Efficiency savings here to stay

An efficiency squeeze on the NHS is seen by the British government as a permanent "fact of life," says health secretary Stephen Dorrell. This puts him on a collision course with the BMA, which earlier this month condemned the imposition of efficiency savings year after year (6 July, p 51).

Mr Dorrell said bluntly that the BMA was wrong to say that there is no scope for further efficiency savings. The health service could not expect to be exempt from pressures that exist throughout society to do things more efficiently. He did not accept that the pressures on the NHS were excessive and added: "I do not believe that any health minister can ever accept that we don't need to continue to look for efficiency gain."

The health secretary, giving evidence on NHS expenditure to the Commons health committee last week, said that cost pressures were within the competence of the NHS to manage. He did not regard efficiency gain as something just required to deal with a difficult year. The target had to be set on its own justification independently of the resources available to the health service. Mr Dorrell said that there was no difficulty when looking for efficiency savings in administration, but it was necessary also to look elsewhere. He agreed that two of the main sources of efficiency savings were reduced length of stay by hospital patients and an increase in day surgery. But he admitted that other factors were beyond financial considerations, such as best value and raising standards.

Meanwhile, the health committee, in a new report, has expressed concern about the resource allocation formula determining the money each health authority receives. Small changes to the formula can add or remove large amounts from an allocation.

The committee urges more research into age weighting, especially the health care costs for each age band. The committee also suggested changes to the "local needs" variables with the addition of homelessness, low birth weight, and ethnic origin. Suspecting that population data based on census returns may be inaccurate, the committee wants a five yearly sample census to be considered.

The Department of Health said that the funding formula is in continuous review and further research is already under way. —JOHN WARDEN, *parliamentary correspondent, BMJ*

Allocation of Resources of Health Authorities, the Second Report of the Health Committee is published by HMSO, price £9.70.

BMA calls for cut in legal alcohol limits

The BMA has called for the maximum blood alcohol concentration for drivers to be lowered to 50 mg/100 ml from the current 80 mg/100 ml.

The association has the support of Alcohol Concern and the Parliamentary Advisory Council for Transport Safety, who have written to the transport secretary, the home secretary, and the chief medical officer, urging them to lower the legal alcohol limit in order to reduce accidents.

The call is reinforced by a new report from the BMA's board of science and education, *Driving Impairment Through Alcohol and Other Drugs*. This says that although there is no scientific answer to the question of what the permitted blood alcohol concentration should be, there is evidence that any detectable blood alcohol increases the risk of drivers being involved in accidents. It says that though it would be sensible to adopt a zero level, legislation would only succeed if it was acceptable to the public and was practical.

The call came on the eve of the government's £1m ($1.5m) media campaign aimed at younger drinkers.—LINDA BEECHAM, *BMJ*

Focus: Westminster

Ombudsman over the surgeon's shoulder

The health service ombudsman has been called the grumbling appendix of the NHS: the complaints he handles are not the most acute in the realm of health care but have to be taken seriously. Although much of the apparatus of a patient friendly NHS is now in place, such as charter standards, the ombudsman serves as a reminder that shortcomings still persist. Indeed, the Commons select committee which shadows his activities recently lamented the repetition of similar failings year after year. Twenty years after the establishment of the ombudsman's office the committee could report "no obvious improvement" in delays in handling complaints, losing notes, and general communication with patients. However, the ombudsman himself, Sir William Reid, observed that the ratio of complaints to episodes of care had swung in favour of the NHS.

Sir William is due to retire at the end of this year, after seven years which have brought exceptional standards of clarity to the ombudsman's investigations and made them models of their kind. A recent innovation is his use of special reports to highlight specific problems, such as continuous care. His report resulted in the NHS Executive requiring health authorities to draw up eligibility criteria for long term care on the NHS. Another special report dealt with a hospital in Salford which had attracted a cluster of systemic complaints—letters going astray, doctors slow to respond to requests for information, and the like. Under the stimulus of that report other hospitals have reviewed their administrations.

These are commendable outcomes, but are they enough to justify the 20 years of Herculean effort that has characterised the ombudsman's work? Although the ombudsman has the powers of a high court judge, are his cases really commensurate with his status? There are surely more things wrong with the NHS than the rude consultants or bungling bureaucrats who blight the ombudsman's world.

The meticulous investigation of everyday mishaps also tends to give the impression of a health service that is perfect in other respects—which manifestly it is not. The exclusion until now of clinical malpractice from the ombudsman's jurisdiction, for example, places a question mark over the order of priorities. The inclusion of such complaints this year has in fact opened a new chapter in the ombudsman's progress. His office is gearing up for it by appointing clinical advisers (13 July, p 118), and the first investigation into a complaint about clinical judgment has begun.

The NHS now pays more than £160m a year in negligence claims settled out of court—a sum that is beginning to alarm MPs. This year the NHS has set up a litigation authority and a clinical negligence scheme for trusts; league tables will in future compare clinical performance between hospitals. All these moves will throw fresh light on the incidence of medical accidents and how they may be reduced.

The arrival of the ombudsman on the scene should be an important corrective to the general perception of the profession's inertia towards malpractice. Two weeks ago a London inquest heard how a patient was given 30 mg of diamorphine instead of 3 mg because of a badly written prescription. Sooner or later such an incident will come before the ombudsman and invite a recommendation that prescription doses should be written in words, like cheques. There is now a locus for the medical royal colleges and the General Medical Council to be more involved in the ombudsman machine, for it is only a matter of time before precedents in matters of clinical practice and medical education are set according to the findings of the ombudsman.—JOHN WARDEN, *parliamentary correspondent, BMJ*