US doctors accused of misusing embryos

Reproductive medicine in the US is being shaken by a scandal that involves one of its foremost leaders. Dr Ricardo Asch, a developer of gamete intrafallopian transfer and author of six textbooks, is one of three Californian fertility specialists accused of taking eggs from patients, fertilising them, and then implanting the embryos into unrelated women.

His codefendants are Dr Jose Bulmaceda and Dr Sergio Stone; all three are members of the faculty at the University of California at Irvine. The three are also accused of selling embryos to research laboratories. So far, at least 17 women and couples have filed suits against the doctors and the university.

In 1992 staff members of the fertility clinic began to suspect that embryos were being misappropriated. A few reported their suspicions to their employer, the university. The university failed to open investigations until September 1994, but the local newspaper, the *Orange County Register*, heard about the reports and began its own investigation.

Fertility centres routinely use hormonal manipulation in selected infertile women. But Asch and his colleagues are accused of using drugs that have not been approved in the US to stimulate ovaries to produce 40-50 eggs, about four times as many as is common practice, according to fertility specialists who have spoken publicly.

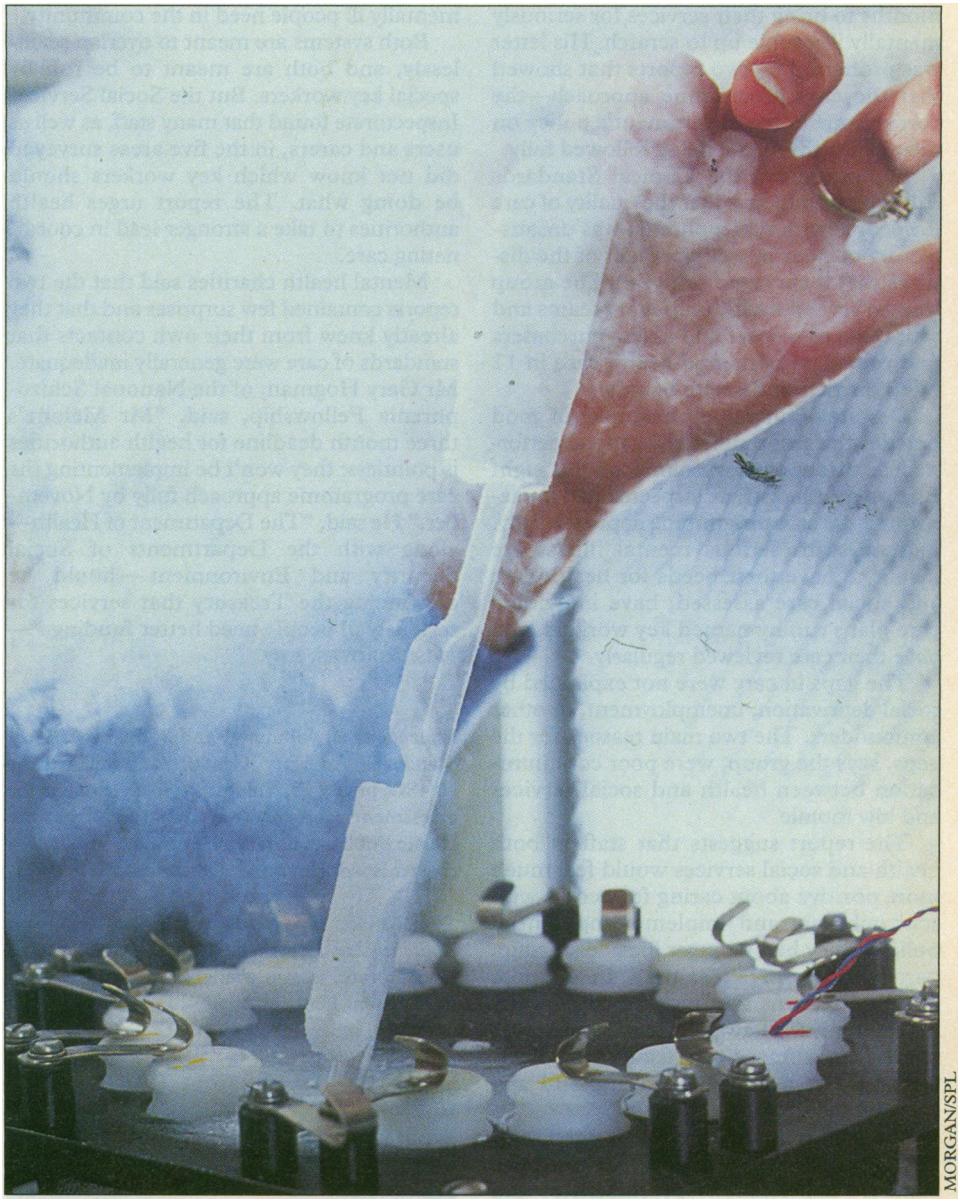
According to the lawsuit, the extra eggs were fertilised in vitro and then implanted into as many as 40 other women, resulting in the birth of at least eight children who are genetically unrelated to the women who delivered them.

Ethicists have condemned the practice, but they also say that the crisis was predictable. According to Professor Arthur Caplan of the University of Pennsylvania's genetics centre, at least 30 000 embryos are now being preserved by freezing in the US. Such numbers, combined with the absence of explicit law, present a temptation. "We're lucky we came this far," Professor Caplan told the *Baltimore Sun* last week. "I was just surprised it would come at such a leading facility with guys with such fine reputations." But the underlying problem is society's refusal to confront the difficult moral issues. "We just turned our eyes and didn't want to get involved," Professor Caplan said. "There just hasn't been the political will."

The doctors' lawyers say that California has not decided who, if anyone, owns harvested eggs or frozen embryos. The case also raises questions about the university's role. Many people are saying that the university protected its three faculty members by failing to investigate allegations for two years, until they were made public by the press. The administration has denied the accusations, and the chancellor, Professor Laurel Wilkening, said that she failed to act sooner partly because she could not believe that doctors could behave in such ways. "I have never encountered such depraved behaviour on the part of faculty members in my entire life," Professor Wilkening said recently.

The university is also a defendant in the lawsuit. It and the doctors are accused of betraying patients in a "conspiracy" to increase the fertility centre's success rate. And the university, the suit alleges, bought the silence of whistleblowers who might have exposed the scheme. The three doctors also say that the debacle is the university's fault because it failed to provide guidelines for its staff.

This month the university announced that even though two of the doctors hold tenured posts in the faculty it will not provide legal representation for them. In fact, it has taken steps to fire them. Termination proceedings against Dr Asch and Dr Stone will begin in September and are expected to last at least a year. Dr Asch and Dr Stone will continue to receive their annual salaries of £78 000 and £60 300—JOHN ROBERTS, North American editor, *BMJ*



MORGAN/SPL

The absence of an explicit law led to the temptation to misuse embryos

Improvements in mental health care called for

The British health minister, Mr Gerald Malone, has written to NHS trusts and health authorities and given them three months to bring their services for seriously mentally ill people up to scratch. His letter was prompted by two reports that showed that the care programme approach—the cornerstone of the government's policy on mental health—is not being followed fully.

A report from the Clinical Standards Advisory Group says that the quality of care for people with schizophrenia was unsatisfactory or poor in well over half of the districts that it surveyed last year. The group trained several multidisciplinary teams and sent them to inspect and assess purchasers and providers of mental health care in 11 NHS districts and health boards.

Despite finding many examples of good practice the group called the general performance disappointing. None of the eight English health districts inspected had implemented the care programme approach fully. Patients with serious mental illness are meant to have their needs for health care and social care assessed, have individual care plans run by named key workers, and have their care reviewed regularly.

The gaps in care were not explained by social deprivation, unemployment, or other confounders. The two main reasons for the gaps, says the group, were poor communication between health and social services and low morale.

The report suggests that staff in both health and social services would feel much more positive about caring for people with schizophrenia and implementing central policy if they had stronger local leadership, particularly from psychiatrists. In addition, the report warns that moving community psychiatry nurses away from consultant led teams into primary care teams may divert nursing care away from the most ill and vulnerable patients.

The report recommends that purchasers and providers should listen to the local experts—experienced psychiatrists and social workers—when contracting for mental health services. It says that contracts must specify that central guidance is implemented and audited and suggests that its own assessment protocol could be used to conduct such audits. The new standardised protocol was used by the inspection teams to rate 20 key elements of each mental health service and to give each a score.

A similar but less comprehensive protocol was used by the Social Services Inspectorate to produce its latest report on mental health care. The inspectorate, a division of the Department of Health that monitors the quality of the provision of social services, also concluded that the care programme approach is not being followed consistently.

The inspectorate assessed five social services departments in England and found patchy and sometimes inadequate implementation of national mental health policy. Part of the problem, says the report, is the splitting of responsibility between health and social services.

On the one hand, health authorities are expected to set up and monitor care programmes for all patients receiving specialist mental health care; on the other hand, social services departments are responsible for assessing and providing the social care that mentally ill people need in the community.

Both systems are meant to overlap seamlessly, and both are meant to be run by special key workers. But the Social Services Inspectorate found that many staff, as well as users and carers, in the five areas surveyed did not know which key workers should be doing what. The report urges health authorities to take a stronger lead in coordinating care.

Mental health charities said that the two reports contained few surprises and that they already knew from their own contacts that standards of care were generally inadequate. Mr Gary Hogman, of the National Schizophrenia Fellowship, said, "Mr Malone's three month deadline for health authorities is pointless: they won't be implementing the care programme approach fully by November." He said, "The Department of Health—along with the Departments of Social Security and Environment—should be convincing the Treasury that services for seriously ill people need better funding."—TRISH GROVES, *BMJ*

Schizophrenia, volumes 1 and 2, by the Clinical Standards Advisory Group, is published by HMSO, price £15. Volume 2, which contains the assessment protocol, is available free from the Health Publications Unit, Heywood Stores, Manchester Road, Heywood, Lancashire OL10 2PZ.

Social Services Departments and the Care Programme Approach: an Inspection, by the Social Services Inspectorate, is also available from the Health Publications Unit.

Professor Andrew Sims chaired the committee on schizophrenia

Doctors and managers must improve relations

More effort must be made over the next few years to improve relationships between doctors and managers. This is one aspect of the present NHS that is not healthy, the retiring chairman of the Audit Commission says in the commission's annual report for 1994-5. Sir David Cooksey calls for the role of management to be developed in conjunction with the clinical role. In some cases, he says, doctors need to come to terms with economic and organisational reality. The two groups should come together "to agree protocols, to carry out meaningful clinical audit, to apply the results of research, and to challenge the cost effectiveness of both new and established treatments."

This agenda was set out in a report by the commission earlier this year (*BMJ* 1995; **310:** 687).

Although the NHS reforms offered exciting opportunities to improve the quality of the services provided in primary and secondary care, Sir David believes that they still have to bed down. He is uncertain how long the improvements will take to come to fruition in the current political climate.

The most fundamental change was the purchaser-provider split, but the retiring chairman says that if the separation is to realise its potential a lot more has to be done to develop the purchaser role. "It is not yet clear," he says, "that all those concerned with the assessment of needs and rationing of services have learned to do so in a way that is perceived to be fair and appropriate."

Sir David criticises the lack of robust data, which are needed to analyse activity to improve services. He suggests that the NHS could learn from the experience of local government by extending the use of competitive tendering to make support services, such as catering and portering, more cost effective.

Commenting on the criticism of the relations between doctors and managers, the deputy director of the National Association of Health Authorities and Trusts, Mr Derek Day, said that "everyone in the NHS recognises that good health care requires clinicians and managers to work together in an ongoing relationship" and pointed out that a working party with the BMA, the Royal College of Nursing, the British Association of Medical Managers, and the Institute of Health Services Management aims to produce a statement of shared values to help doctors and managers to work together.

Over the next two years the Audit Commission plans to report on the care of elderly patients with fractured neck of femur, accident and emergency services, the commissioning of cardiac services, maternity services, and NHS supplies procurement. It will also produce a report on troublesome youth jointly with local government.—LINDA BEECHAM, *BMJ*

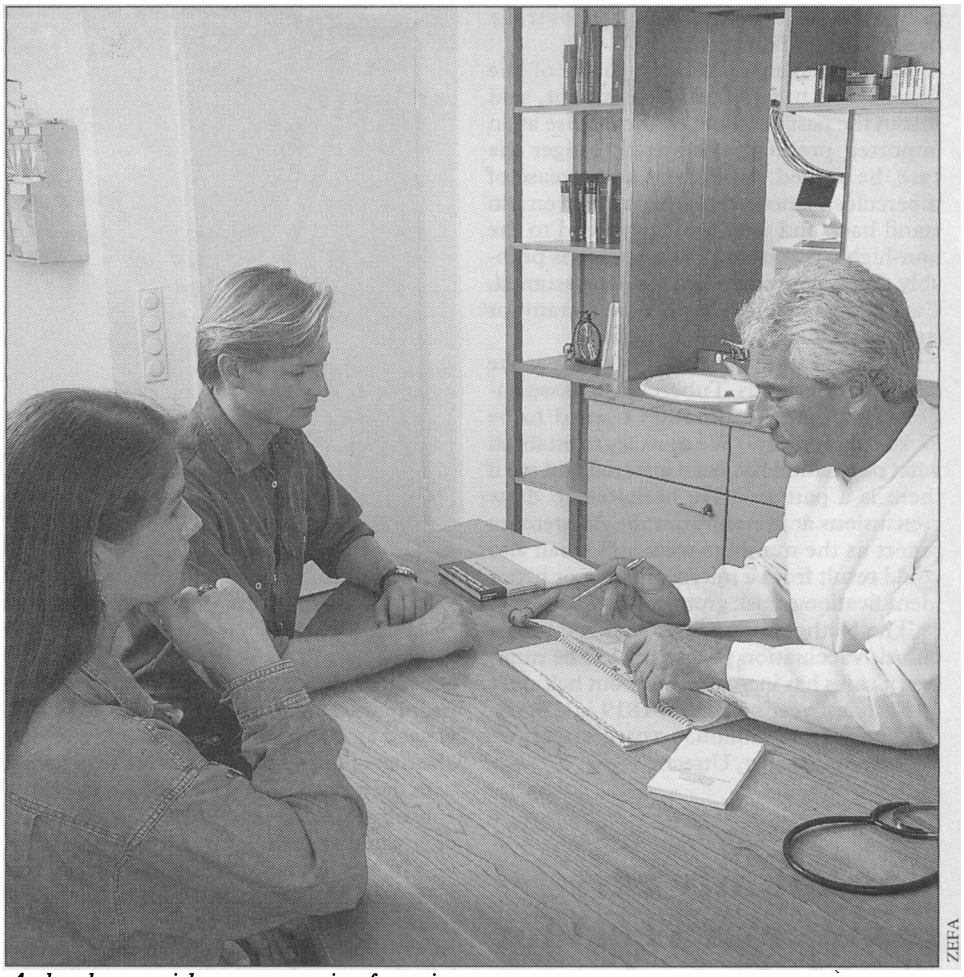
More hospitals are privatised in the US

Privatisation is sweeping across the American public hospital system. Last month New York City's huge city run health system for poor people was threatened with the prospect of becoming the latest—and largest—system to be privatised under a plan suppported by the Republican mayor, Rudolph Giuliani.

The city has been a leader in providing care for poor people through its Health and Hospitals Corporation, which runs 11 short stay hospitals, including the world famous Bellevue Hospital; five long term care hospitals; 76 clinics; and the city's emergency medical system. On an average day the system serves 6500 patients. But it is inefficient and costly, said the report of a five member panel chosen to investigate it. And in a country where the private marketplace is rapidly expanding and citizens are demanding tax cuts, a government programme cannot survive, the report said. The panel recommended selling off those hospitals that would be sought by private purchasers and, according to a report in the *New York Times*, would allow the others simply to close down.

New York's proposal comes just a month after Los Angeles decided to cut its government medical spending by almost a half and to close 36 of its 45 health centres. Other cities, faced with cutbacks from the federal government, are looking at ways of trimming health costs.

According to experts interviewed after the New York report was released, private insurers will almost certainly close many hospitals. In cities where capitated care—a system in which doctors are prepaid to deliver all the medical care for their patients—has become dominant, such as Seattle and Minneapolis, as many as 35% of hospital beds have been closed—JOHN ROBERTS, North American editor, *BMJ*



ZEFA

An hourly rate might mean more time for patients

Hourly rate for some doctors proposed in Germany

The president of the German chamber of physicians has proposed that doctors who are contracted with the national health insurance scheme should be paid on an hourly basis. Dr Ellis Huber's scheme would replace the traditional system whereby doctors are paid on the basis of the number of patients they see and the services they perform. At present the official scale of fees for doctors lists about 2500 items, ranging from a simple consultation in a general practitioner's office to open heart surgery. About 1700 items are included in a scale list, which is part of the contract between doctors and the national health insurance plan.

The present system results in doctors seeing as many as 85 patients a day in their consulting rooms. Dr Huber believes that a sum of DM200 (£88) an hour would be appropriate for the average general practitioner. Of this, DM110 (£48) should go towards practice costs, such as rent, staffing, and technical equipment, while the remaining DM90 (£40) would be the doctor's fee. In Dr Huber's opinion his proposal would allow doctors to devote more time to patients.

Dr Frank Ulrich Montgomery, president of the Marburger Bund, the association of employed hospital doctors in Germany, conceded that there was "a grain of truth" in Dr Huber's criticism and that there were some "black sheep" among doctors, who tried to exploit the present system. But such cases were rare. Nor is the president of the association of doctors who participate in the national insurance scheme in Freiburg/South Baden enthusiastic about Dr Huber's idea. Dr Peter Schwoerer calculates that doctors with a lump sum of DM200 an hour would "certainly be better off" so long as they had to deal only with patients who needed a consultation and a few prescriptions. But doctors would begin to lose money as soon as more sophisticated diagnostic and therapeutic procedures were required. Overall the proposed scheme would be "hostile to patients." Dr Schwoerer also pointed out that his association was working on a new remuneration concept that mixed time related and service related fees and could reduce the number of items in the valuation scale list from 1700 to 1300.—HELMUT L KARCHER, medical writer, Munich

Increase in tuberculosis causes concern to Dutch

Dutch doctors are concerned that the latest tuberculosis figures suggest that the disease is spreading faster than expected from high risk groups to the general population. Last year cases of tuberculosis in Amsterdam increased by 37%, reaching the highest figure since 1966, according to the tuberculosis prevention department of the city's public health service. Numbers increased by 74% among people born in the Netherlands, compared with an increase of only 20% among people born elsewhere, such as asylum seekers and immigrant communities.

Cases have mainly come from immigrant groups from countries with high rates of tuberculosis, such as Somalia and Turkey. But the proportion of patients of non-Dutch origin fell from 68% in 1993 to 59% last year. At the same time the proportion of cases among other high risk groups, such as users of hard drugs and people who are HIV positive, either fell slightly or remained constant.

Using DNA techniques, the public health service hopes to ascertain whether the disease is spreading from traditional risk groups. The Amsterdam health services are now working with the National Institute of Public Health and Environmental Protec-

tion to type all the bacteria isolated over the past two and a half years.

Dr Henk van Deutekom, head of the Amsterdam tuberculosis department, said that in the past doctors saw the disease as an imported problem. This is no longer the case, he argued. "If there is an increase of tuberculosis among risk groups then you can stand back and wait for it to spread to the non-high risk groups. Tuberculosis is probably more infectious than we had assumed. Casual contact such as in a pub, tram, or supermarket can lead to infection."

Dr Jaap Veen, a senior consultant at the Royal Netherlands Tuberculosis Association, said that the situation needed to be looked at carefully. "We must try to establish what population has been infected and see if there is a pattern." He hesitated to draw conclusions at present from the Amsterdam report as the numbers were still small and could result from a microepidemic or better identification of risk groups.

The Netherlands has no national tuberculosis vaccination programme. The number of cases has increased by about half since 1987 to last year's figure of 1819 in a population of 15.6 million.—TONY SHELDON, freelance journalist, Utrecht

PRINCE/FORMAT

Many disabled people have to buy their own wheelchair

Community care means extra cost for disabled people

Nearly a fifth of disabled people in Britain have to turn down help from local authorities because they cannot afford the services, according to a survey on the impact of the government's policy on care in the community. The survey, commissioned by the charity Scope, says that many disabled people now have to pay for services that they previously received free.

The survey was of more than 1500 disabled people and 1300 carers during the summer of 1994. What emerged was a picture of charges being introduced for services that had been provided free, means testing, and the rationing of essential support.

In addition, only 13% of carers had received an assessment of need. Even when an assessment is provided, the report says that there is evidence of considerable dissatisfaction with the process: "Many respondents feel that assessors do not look at their individual lifestyles, but try and match them on narrow criteria. If they do not fit the boxes they do not receive the help they feel they are entitled to receive."

Many respondents reported problems with wheelchair services. Because of financial constraints the choice of chair is limited and recipients may face long delays in delivery. The report says: "Many people therefore have to buy privately or apply to charities for help in order to get a suitable wheelchair."

As far as medical care is concerned, 89% of disabled people and 84% of carers are satisfied with the service they receive from their general practitioner, although some disabled people were concerned that they might be viewed as a burden. Three quarters of disabled people and their carers are also happy with the service from their hospital doctor or consultant. Reservations focused chiefly on delays in diagnosis.

The report states: "Disabled people and carers could benefit from GPs' increased freedom to purchase services for patients. Many practices are now adopting more holistic approaches which are especially suitable for the management of long term chronic and disabling conditions; for example, massage and stress relief clinics."

Brian Lamb, coauthor of the report and Scope's head of campaigns, said: "First hand experiences of disabled people and their carers show that community care is a system that is in danger of failing its original aim to improve quality, choice, and efficiency and has in fact forced many to rely on the unpaid care given by family and friends."—CLAUDIA COURT, *BMJ*

House of Lords champions researchers' cause

A new deal for the 20 000 researchers in Britain who work on contracts has been advocated by the House of Lords Select Committee on Science and Technology. Describing them as a "scientific underclass," the lords said that contract staff should have the same status and rights as the permanent academic staff in universities, better management of their careers, and funding to bridge the gaps between contracts.

The inquiry reflects concern about the rapid increase in non-tenured staff employed on research funded by short term grants. Their number in medicine and other disciplines has doubled in 10 years because changes in the universities' funding regime mean that research can attract increments to the block grant at the expense of growth in the number of established academic staff—professors, readers, and lecturers.

The number of researchers completing contracts in any one year is about five times the number of vacancies likely to arise in established posts. While acknowledging the "flexibility, dynamism, and vitality" of short term research contracts, the select committee believes that important defects such as insecurity and poor morale must be removed if the system is to continue.

The evidence is that researchers working on contracts in the sciences are disadvantaged in terms of career progression, salary, continuity of work, access to facilities, and participation in the affairs of the university that employs them. Although the universities did not set out to create a scientific underclass, the lords say that that has been the result, and they criticise it as "maladroit administration of a valuable, highly trained human resource."

The neglect of the conditions of contract staff, though understandable, does not absolve the universities from arriving at better arrangements without delay, the committee states. In its view there is a clear duty on the university to make known to each researcher working on a contract whether or not he or she has a realistic chance of an established university post.

Other recommendations are for more five year fellowships and the removal of structural barriers to the employment of women in science by the use of improved maternity provision, child care, and retraining. The one year research master's degree (MRes), to be tried out in the coming academic year as a preliminary to a doctorate in philosophy (PhD), should not become compulsory until its benefits have been ascertained.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Academic Research Careers for Graduate Scientists, a report of the House of Lords Select Committee on Science and Technology, is published by HMSO, price £12.95.