Tobacco companies seek to pay \$300bn as lawsuit settlement

Terri Rutter, *Boston, Massachusetts*

The United States tobacco industry is moving towards a historic settlement over compensation for tobacco related illnesses. Discussions have centred on an industry settlement of \$300bn (£188bn) in return for immunity from future litigation.

In meetings that lasted for two weeks representatives from the two largest US tobacco companies, RJR Nabisco Holdings and Philip Morris, and their lawyers met with attorneys general from at least 22 states and with other interested parties.

Although all sides admitted that the talks were only in the early stages and may not succeed, tobacco companies are clearly eager to negotiate an agreement that would protect them from current and future lawsuits. So far, 23 states have filed suits seeking reimbursement for medical costs for treating patients with smoking related illness and countless suits have been filed by individual people and families.

The settlement under discussion would entail the tobacco industry paying up to \$300bn into a fund to be paid out over the next 25 years to people and states making claims against it.

The industry would need to agree to strict limitations in cigarette advertising and for tobacco to be regulated by the Food and Drug Administration (FDA), which would become the Food, Drug, and Tobacco Administration.

Under the jurisdiction of the FDA the tobacco companies would abide by the agency's restrictions on cigarette advertising, including a ban on billboard advertising and the use of pictures of real people in advertisements. The administration's rules would also prohibit advertising campaigns targeted at young people, such as the Joe Camel cartoon character, and restrict tobacco companies' sponsorship of athletic events.

"In America and Europe, a lot more is spent on tobacco promotion than on tobacco advertising, so laws that just ban advertising would let marketing continue," said Professor Richard Peto from Oxford, the main epidemiological witness in the first of the pending state lawsuits.

The number of teenagers who smoke has risen in the past few years, and anti-tobacco proponents, including former FDA commissioner David Kessler,

News of a possible \$300bn settlement caused tobacco shares to rise

attributed the increase to advertising that appealed to young people. In addition, the industry would be required to establish a fund for educating the public, and especially young people, about the risks of smoking.

"Our goal has been to ensure that the opportunity for fundamental change not be lost or compromised away, that nothing be done to weaken the FDA rule to protect children from the mar-

keting and sale of tobacco products or to weaken FDA authority to oversee the tobacco industry," said William Novelli and Matthew Myers in a statement from the National Campaign for Tobacco Free Kids, which is participating in the talks.

The current talks follow last month's admission by the Liggett Group, the smallest of the major cigarette makers, that nicotine is addictive and its offer to submit documentation that could potentially indict the entire industry (29 March, p 919).

News of the settlement talks caused stock prices in both tobacco companies to rise sharply, an indication that even such a large sum as \$300bn would be worth while for the tobacco industry, which is currently spending about \$900m a year in legal fees.

Lonnie Bristow, immediate past president of the American Medical Association, said: "It is critical that any resolution assures a reduction in the illness and death caused by smoking as well as FDA regulation of the tobacco industry." □

Any settlement in the United States over compensation for tobacco related illnesses may have only limited repercussions on the rest of the world, writes Clare Dyer.

Groups of people with smoking related illnesses are suing tobacco companies in Britain and Canada as well as the US, and individual cases are being brought in Italy, France, and Finland. But the US situation is unique in that a powerful and well funded alliance of states' attorneys general and law firms have been able to meet the tobacco giants on near equal terms. In Britain, NHS trusts have stayed out of the group litigation, run as a David and Goliath battle by a single medium-sized law firm, Leigh, Day. Denied legal aid after the initial research, the firm is bringing the action on a no-win, no-fee basis.

Product liability cases are notoriously hard to win in the British courts, where judges rather than juries make the decisions. But senior partner Martyn Day is bullish about the prospects of a settlement. He points out that one of the two tobacco companies being sued in Britain, Gallahers, is owned by the US company American Brands. He argues that the British system, under which a single judge hears all the cases and produces a judgment that can be relied on by others—in this case, he believes, up to 20 000 people with lung cancer a year—makes a settlement an attractive proposition for manufacturers. "If the American tobacco companies walk away with their share prices intact, I would be very surprised if, given the all or nothing nature of the British system, they didn't look at it very seriously here."

The *BMJ*'s Question Time

The *BMJ* put a series of questions to the Conservative, Labour, and Liberal Democrat health spokesmen in an attempt to elicit more details about how they would tackle some of the pressing health issues. In the run up to the general election on 1 May we publish the questions and replies from the Conservatives' **Stephen Dorrell**, Labour's **Chris Smith**, and the Liberal Democrats' **Simon Hughes**.

How will you seek to influence the real determinants of the health of the populace: poverty, transport, housing, agriculture, and food?

Conservative

The *Health of the Nation* white paper, which was published in 1992, was the first ever clear and comprehensive strategy for public health. It has set demanding targets in five key areas for the year 2000 and beyond. Already, significant progress has been made on most of the targets. Following recent advances in our knowledge of environmental matters, particularly air quality, we have recently been able to add a new environment key area to the Health of the Nation strategy.

Labour

Labour recognises the broader influences on health and lifestyle, such as education, employment, housing, and the environment. By appointing a minister for public health we will give public health the emphasis it needs right across government; by banning tobacco advertising we will put the health of children first; by setting high standards for air quality we will reduce atmospheric pollution; by helping young people off benefits and into work through our welfare to work programme and the introduction of a minimum wage we will reduce poverty and income inequalities; and by the phased release of capital receipts we will start to target poor housing. By these and a host of other measures we will show our commitment to creating healthy communities that nurture healthy people.

Liberal Democrats

Travel delays and road congestion cost billions of pounds, and pollution damages the health of millions of people. We will enable councils to introduce road pricing in the most congested urban areas and use the money to support public transport and to improve cycle and pedestrian access. We will also encourage people to drive more fuel efficient cars by cutting the annual car tax from £145 to £10 for cars up to 1600 cc, funded by gradually raising the duty on fuel by approximately 4p per litre. One of our priorities is to build more affordable and secure housing by encouraging partnerships between the public and private sectors and housing associations to build high quality homes to rent and buy. We will begin the phased release of capital receipts from past sales of council houses and allow the money to be used to build new homes. We will ensure that by the year 2000 no one is forced to sleep on the streets. We will require every council to set up self funding rent deposit schemes to help homeless people take up private tenancies, and we will fund more short term hostel places. We will ensure that food is healthy and safe by creating an independent and powerful food commission. This commission would be separate from the Ministry for Agriculture, Fisheries and Food and be responsible to parliament for food quality and safety.

Increasing amounts of evidence suggest that income inequality is a major determinant of health. In Britain income inequality has increased over the past 20 years. Do you agree that income inequality is a major determinant of health? If you do, what action do you think should be taken to reduce the damage to health from income inequality?

Conservative

Health is improving in all regions and across all social groups. There are no easy explanations of health variations, and the government has invested in research to ensure that interventions to tackle health variations are effective. Guidance has been issued to health authorities on the need to address variations. Britain's economic success has meant rising average incomes for all family types and falling unemployment. Research by the Institute for Fiscal Studies has shown significant movement into and out of the lowest tenth of the overall income distribution.

Labour

Labour understands how important poverty and inequality are for health. We won't stand idly by while people's health suffers. A Labour government will establish an independent inquiry into inequalities in health to update the Black report of 1980. The inquiry will examine the impact of inequality, poverty, poor housing, and heavy pollution on people's health; expose the different health and life expectations of people in different classes and different parts of the country; and draw up recommendations for action. Sir Donald Acheson, former chief medical officer, has been invited to lead the new inquiry. Labour will want the enquiry to begin as soon as possible, and the recommendations of the inquiry will be used to inform Labour's plans to publish a revised *Health of the Nation* document to coincide with the 50th anniversary of the start of the NHS in 1998. The new *Health of the Nation* will include local health targets and record the significance of poverty and inequality in fostering poor health.

Liberal Democrats

Income inequality is a major determinant of health and a key component of Liberal Democrat thinking. The government has failed to act effectively to deal with the health effects of poor housing, deteriorating environment, unemployment, poverty, stress, and poor education. All these, with the current lack of preventive medicine, push up costs in terms of quality of life, to people, industry, and the NHS. A healthier nation and a more cost effective NHS depend on shifting the emphasis towards prevention and tackling the root causes of ill health, particularly poverty and homelessness. Liberal Democrats are committed to a radical and

comprehensive programme which includes taking nearly 500 000 low earners out of income tax altogether by raising tax thresholds paid for by introducing a new top tax rate of 50p on taxable income of over £100 000 per year; reinstating free eye and dental checks; improving health education; guaranteeing nursery education for all 3 and 4 year olds; freezing prescription charges; and replacing income support and family credit with a simpler, more efficient low income benefit that increases financial incentives for people going back to work. We would put health promotion at the heart of government policy, requiring all departments to assess the impact of their policies on health. Each year there will be an independent report, published and debated in parliament, on the state of the nation's health.

What will you do to discourage teenagers from taking up smoking?

Conservative

Price and parents have been shown to be the major determinants of whether young people take up smoking. In 1993 the government gave a commitment to increase the real level of tobacco duties by 3% every year: a 10% increase is estimated to lead to a fall in consumption of between 3% and 6%. Since November 1993 the average price of a packet of 20 cigarettes has gone up by over 40p. The 1996 budget alone increased the duty on a packet of cigarettes by 15p. In real terms the price of tobacco is now about 50% more than it was in 1979. In 1996 the government launched a major programme aimed at dissuading teenagers from smoking: £3m will be invested in it over three years. It addresses the reasons why young people start smoking and seeks to create a positive lifestyle as relevant to the two thirds of teenagers who don't smoke as to the third who do. The Health Education Authority is running a national smoking education campaign, costing £5.5m in 1996, targeted particularly at parents. International evidence shows that a statutory ban on tobacco advertising is no guarantee of success in reducing smoking. The United Kingdom has a better record than both Norway and Finland in reducing smoking in the period since they introduced their advertising bans. The two EU countries with the best record in reducing smoking—the Netherlands and the United Kingdom—both have voluntary controls on advertising. We have reviewed the evidence thoroughly and found little to suggest that a statutory ban would have a significant effect on reducing smoking over and above the impact of our strong voluntary controls.

Conservative health spokesman Stephen Dorrell

Labour

Labour will ban tobacco advertising and work to reduce preventable deaths from smoking. The Tory government set a target for reducing teenage smoking from 8% to 6% of 11-15 year olds. Instead, teenage smoking has risen to 12%. Now every day some 300 children become permanent smokers. The BMA last year produced clear evidence that children smoked the most heavily advertised brands, that tobacco advertising encourages demand. It is estimated that banning tobacco advertising may help 100 000 children a year to stay tobacco free.

Liberal Democrats

We will honour our longstanding commitment to ban tobacco advertising and promotion, including sports sponsorship, except at the point of sale. We will put an extra 5p on the price of a packet of 20 cigarettes. We will make the Health Education Authority truly independent and free to criticise government policy.

Do you think that a policy to reduce the harmful effects of drugs that are currently illegal must consider some legalisation or decriminalisation?

Conservative

No.

Labour

Labour believes that all drugs that are at present illegal should remain so. On the question of medical uses of prohibited substances we agree with the health minister, John Bowis, that: "If it were shown that there were indications for the use of cannabis in specific medical conditions [such as glaucoma and multiple sclerosis] we would not rule it out as a prescribed drug. The supporting data would need to be presented to the Medicines Control Agency for assessment with a view to licensing the preparation."

Liberal Democrats

We will set up a royal commission to examine drugs policy and to tackle the drugs problem at its roots.

Some critics say that the health service cannot function adequately without substantially more money. Because this is unlikely to come from increased income tax, these critics think that there must be an increase in private funds in the system. Do you agree?

Conservative

No. We remain committed to increasing NHS funding year on year throughout the five years of the next parliament, as has been the case since 1979, when the cuts of the previous year were reversed.

Labour

The introduction of the Tories' internal market is costing the NHS £4m a day. Since 1989-90 annual spending on managerial staff has almost doubled from £1.2bn to £2.3bn. In June 1995 the Audit Commission found

that the costs of senior management in some trusts were more than double those in others for no identifiable reason. By ending the internal market we will ensure that money wasted on the contracting bureaucracy will be redirected to patient care. We will also ensure that existing treatments are based on the best evidence and that money is not being wasted on ineffective treatment.

Liberal Democrats

Once again, we are the only party committed to investing an extra £540m each year in the NHS. This will be paid for by closing the loophole that allows employers to avoid paying national insurance contributions on certain benefits in kind and by putting 5p on the price of a packet of 20 cigarettes. We have earmarked £200m to tackle the staffing crisis—which could pay for 10 000 new nurses or 5000 new doctors—and to move to a more preventive approach in health care. We will also ensure that the NHS budget keeps pace with increasing cost pressures.

Most people working within the health service think that rationing of health care is inevitable. They think that priority setting and rationing are the same thing. Do you agree with these two ideas? If you do, how can decisions on rationing best be made?

Conservative

No. The NHS white paper *A Service with Ambitions* stated categorically: “There should be no clinically effective treatments which a health authority decides as a matter of principle should never be provided. Even where the effectiveness of a particular procedure is not in general judged to be high, it might be both effective and appropriate in certain circumstances for an individual patient.”

Labour

Labour believes in a comprehensive national health service free at the point of use where access is based on clinical need. There has always been priority setting in the NHS. However, any decisions about priority setting must clearly distinguish rationing from the decisions clinicians take every day with regard to the best treatment for their patients. Such decisions must be informed by the best evidence and dealt with on a case by case basis. Any setting of priorities must be based on patient need, considering the degree of pain and trauma, rather than simply on waiting times. At present a lot of the current anomalies in the system are a result of the distortions of the internal market introduced by the Tories. The internal market has brought about needless competition and a two tier system in the NHS. As a result of the internal market treatments available to patients are based on purely financial criteria rather than clinical need, with patients of fundholders getting preference over other patients and with the availability of treatment varying from region to region. Labour would end the internal market and end this unnecessary and unfair form of “rationing.”

Labour health spokesman Chris Smith

Liberal Democrats

The Liberal Democrats are the only party willing to be honest about the question of priority setting. Difficult choices about priorities must be faced, and we are determined to involve the public—not only bureaucrats and health professionals—in developing new ways of setting those priorities. Hard choices will inevitably have to be faced, and we believe it is wrong for politicians to bury their heads in the sand whenever the subject of rationing is raised. Putting a million people on waiting lists is no longer an acceptable way of setting priorities.

Do you think all health care should be purchased by GPs, with health authorities concerned with strategic planning?

Conservative

No. We agree with the BMA statement of 17 March which “acknowledged the advantages of maintaining a plurality of commissioning methods.” All options, including fundholding, should be retained, and choices between the options must remain entirely voluntary. No GP should be forced into or out of the commissioning method of their choice, and health authorities must ensure that they involve all GPs in their commissioning decisions.

Labour

Over a 2-3 year period we aim to replace single practice GP fundholding with locality commissioning: bringing together all the GPs and other primary care professionals for an area. In developing this commissioning model we would want to build on the enormous success of the existing commissioning groups, multifunds, and total purchasing groups that have already been developing organically around the country. Under our system health authorities will become strategic bodies, promoting public health, monitoring performance, and disseminating best practice.

Liberal Democrats

We believe that all GPs should be treated equally with a common basis for funding. This would end the current two tier service. All GPs should have the benefits of flexibility and access to services that is currently enjoyed by fundholders. Those who choose to manage their own affairs should be able to do so, either on their own or as part of a consortium. Those who do not will be able to delegate that responsibility back to their local health authority. GPs should not be forced to be business managers if they do not wish to be.

When decisions on health care or spending are made locally how can health authorities be made answerable locally?

Conservative

The performance of local service providers is now open to scrutiny both locally and nationally. Each year their service standards against the patient's charter are published in the performance league tables. Health authorities must hold public meetings, and any major service changes are subjected to a statutory three month period of full local consultation. In addition, health authorities and NHS trusts have been made more responsive to the needs of individual patients by giving GPs a central role in the commissioning of care—a process that has been led by the development of GP fundholding.

Labour

The Conservatives have taken democracy out of the NHS and put secrecy in its place. They have frequently forced through decisions in a manner that rides roughshod over the views of local people. Labour will allow patients and local communities to have a real say in their health service. Our proposals for public hearings will ensure that local people have an opportunity to be heard and a chance to question the NHS, when decisions are made about their local health service. Labour will ensure health authorities and trusts hold meetings in public and strengthen the role of community health councils to put people at the centre of decision making in the NHS.

Liberal Democrats

The Liberal Democrats believe that the local institutions of the NHS must become more accountable to those they serve and more responsive to the needs of patients. We will enable citizens to play a part in setting health policies in their area by building on existing pilot schemes bringing together health authorities and social services departments, within the framework of elected local authorities. We will also give local people a stronger voice in NHS trusts, requiring at least half the membership of trusts to be drawn from the local population. Meetings of trust boards will be opened up to both the public and the press, with citizens, staff, and professionals having speaking rights.

Do you think that managed care has much to offer the NHS?

Conservative

This has many interpretations, a number of which would be unacceptable in the United Kingdom because of potential conflict with the principles that underpin the NHS. Chronic disease management programmes for asthma and diabetes have already made a significant contribution, and the lessons from such programmes are being learnt and applied.

Labour

Managed care is an extremely complex subject. We certainly believe that it is important to look at the overall needs of patients across all institutions and sectors, but it is essential, however, that a patient's clinician remains in control of patient care.

Liberal Democrats

The Liberal Democrats welcome a more evidence based approach to healthcare delivery. In a society where effectiveness is not proved for six out of seven medical treatments we must find out more about which prescriptions are good clinical practice. The managed care model may be beneficial, to a limited degree, in some areas of intervention. We will set up a national inspectorate for health and social care to improve standards and promote patients' interests. This inspectorate would have overall responsibility for monitoring quality of care. It would detail the improvements services require to meet the standards laid down; the closure of facilities that consistently fail to meet those standards; and the publication and circulation of advice on good practice. It would also advise ministers when standards should be improved.

Liberal Democrat health spokesman Simon Hughes

Do you think Britain needs more doctors and nurses?

Conservative

Yes. Since 1979 the number of qualified nurses and midwives in the NHS has risen by around 55 000 and the number of doctors and dentists by 22 500. We are committed to ensuring that this continues. An increase of almost 40% in places for student nurses over three years is already well under way, as is our ambition to increase the number of places for medical students to 5000 a year.

Labour

Britain needs doctors and nurses who feel valued by the service for which they work. Recent polls quite clearly show the effect on morale that this government's market driven policies have had on health service staff. There is a real crisis in recruitment in the hospital service and the additional problems in retaining those already in the service; these are issues that affect all parts of the service, both medical and non-medical. Labour's plans to reintroduce a cooperative integrated health service with less bureaucracy, and a focus on the traditional NHS public service values will restore the morale of those already in the service and encourage others to return. We believe that the staff are the most vital component of the NHS and recognise the vital part that they play.

Liberal Democrats

One of our key priorities is to invest an extra £200m (of the £540m total) in staff recruitment. This funding would be the equivalent of paying for an extra 10 000 nurses or 5000 doctors.

In brief

Three people infected with HIV from blood transfusion: Blood from an HIV positive donor in northwest England escaped detection by the standard screening methods as the donor had only recently become infected. As a result, three patients contracted HIV infection. This is the first such case identified in England since the testing of blood for HIV was introduced in 1985.

Mental health services in Britain on the point of collapse: The Royal College of Psychiatrists has said the government's community care policy is in danger of falling apart. It has published a manifesto for mental health and a nine point action plan to address the crisis. It says mental illness should receive the same priority as physical illness.

Arizona law prohibits doctors from prescribing cannabis: A bill has been passed prohibiting doctors in Arizona from prescribing marijuana. The move overturns last year's decision to allow patients who are terminally ill or in severe pain to receive prescriptions of the drug.

HIV positive people can get insurance in United States: The American insurance industry has acknowledged for the first time that being HIV positive is no longer an automatic death sentence. An Illinois based company has said that for steep premiums it would offer policies to HIV positive people.

Warning over risk of childhood malnutrition in Britain: A report from Save the Children warns that unless immediate action is taken increasing numbers of children will be at risk of malnutrition into the next century. They say that many families—despite their resourcefulness and best efforts—simply cannot afford a balanced diet for their children.

Medical charities call for end to rationing of drug treatment: Nine medical charities in Britain have called on the political parties to put forward clear proposals to ensure that clinically proved treatments are freely available to all who need them, regardless of where they live.

SALLY WEIR/COMFORT/ISIS

The private finance initiative has slowed down building work in the NHS

PFI condemned as a failure

Jackie Cresswell, *London*

In a damning report health service managers have condemned the government's private finance initiative as a failure.

The report, published this week by the Institute of Health Services Management, paints a picture of delay and bureaucracy and emphasises that no scheme of importance has got under way.

The King's Fund echoed the condemnation of the initiative in a factual briefing paper, which describes the process as long and tortuous.

The institute's report, *Building Services and Servicing Buildings*, states that the scheme was launched without any clearly defined or detailed process to make it work, which has led to major delays and investors dropping out. It adds that the private

finance initiative has also been hampered by questions about its legality within current regulations. The report, produced by Meara Management Consultancy, also states that despite the obvious pitfalls both major political parties seem to be committed to financing from the private sector.

Karen Caines, director of the institute, said: "Whatever successes are claimed for the private finance initiative in other parts of the public sector, its track record in the NHS has been one of delay, bureaucracy, and immense frustration."

She added: "It needs to work in a way that suits the NHS, with an understanding that large hospitals are not really the answer."

The institute makes a series of key recommendations about areas that need rethinking if the initiative is to have a chance of working, and these include a clear view of the kinds of health-care facilities needed in the future and clear specifications

from the NHS on what output the asset is intended to deliver.

It will also set up an "NHS PFI" watch to comment regularly on the progress of the initiative.

The King's Fund, in a paper presenting facts on the initiative, says that many organisations have withdrawn from the private finance initiative scheme because the costs of tendering are substantial and the complicated process generates extra management costs for the trust.

It outlines widespread concerns in the public and private sector about the scheme, particularly about the effect of a 30 year commitment within a rapidly changing NHS.

Robert Maxwell, chief executive of the King's Fund, said: "I have no objection to the private finance initiative in principle, but in practice it has been a real pain and in a strategic sense it has been really bad news. The scheme has been a recipe for delay and complications." (See pp 1214, 1266.) □

Canada retreats over tobacco laws

David Spurgeon, *Quebec*

Tough anti-smoking legislation in Canada has had to be softened after strong opposition from special interest groups.

In Canada's biggest city, Toronto, defiance of a strict anti-smoking bylaw has forced the city council to amend the legislation. This comes at the same time as the federal government has loosened the restrictions embodied in its controversial anti-tobacco legislation to allow the logos of tobacco companies to appear on racing cars and dri-

vers' clothing after criticism about the potential loss of income from sponsorship of racing events (22 February, p 539). A federal election is likely to be announced in April.

Since Toronto's anti-smoking bylaw came into effect on 3 March restaurant owners and customers in Toronto have defied the law and made it unworkable (5 April, p 994). The law prohibited smoking in restaurants and bars except in enclosed, separately ventilated

rooms comprising no more than 25% of the establishment. The new bylaw allows large restaurants to set aside 10% of the seating area for smoking and smaller restaurants, 25%. If restaurants want to use a separately enclosed and ventilated area for smoking, under the new law it can occupy up to half the seating area, but it must be built by 1 January 2000. After that, smoking will be banned completely outside such smoking rooms.

In a separate move the province of British Columbia has announced that it will introduce legislation to make tobacco companies pay for healthcare costs associated with smoking. □

Health authority pays out £2m over radiation blunder

Clare Dyer, legal correspondent, BMJ

North Staffordshire Health Authority has agreed to a £2m (\$3.2m) settlement plus substantial costs for 95 victims of a hospital blunder which resulted in patients with cancer being underdosed with radiation over nine years.

More than 1000 patients at the North Staffordshire Royal Infirmary in Stoke on Trent received dosages between 5% and 35% lower than intended. The mistake was made by the hospital's senior physicist, Margaret Grieveson, in 1982, when the hospital took delivery of a new computer designed to calculate radiation dosage.

Miss Grieveson instructed staff to adjust for a correction

factor according to the distance of the radiation source from the skin, unaware that this had already been built in. The error came to light when a new computer system was installed in 1991. The mistake affected patients with a range of cancers, including those of the bladder, endometrium, lung, oesophagus, and cervix, who were treated by the isocentric technique, in which the x ray machine is rotated around the body.

An independent inquiry set up by the health authority found that of 1075 patients who received wrong dosages, more than 400 had since died and another 91 had had a recurrence of their cancer, including 26 who

had their bladders removed. The report said that it was impossible to say how many had died unnecessarily, but one of its authors estimated the numbers as "in the tens rather than the hundreds."

James Evans, chairman of the steering committee for the patients' solicitors, said the cases had taken five years to settle because proving that underdosing had materially affected the course of their illnesses was a major stumbling block. "These were people who already had life threatening illnesses." He said that those with "good claims"—those substantiated by expert evidence—would receive as much compensation as a court would have awarded, "and we've got something for the others as well."

The damages and costs will be met mainly by the NHS Litigation Authority with only a small proportion falling on the health authority. □

General Medical Council attacks medical training

Jacqui Wise, BMJ

The General Medical Council has criticised the training and education of young doctors in Britain in their first year after graduation.

In *The New Doctor* the GMC lays out a series of recommendations that need to be implemented by April 2000 to improve the clinical and educational experience of preregistration house officers.

The GMC made a series of visits to medical schools starting in 1995 and found that, although some new preregistration house officers had high quality training, for many it was substandard.

Some posts were educationally inadequate, and in others the new doctors were not properly supervised or supported. The council said that such problems were often compounded by poor organisation within hospitals and inadequate facilities.

Professor Charles George, chairman of the GMC's education committee, said: "We want to ensure that the quality of training in all preregistration house officer posts is brought up to the standard of the best there is at present and make the preregistration year an enjoyable and worthwhile experience for all doctors."

The booklet sets out the clinical, educational, and personal needs of preregistration house officers and clarifies the responsibilities of tutors and other staff who work with them. It says that it is important that staff who teach preregistration house officers get adequate training and support to carry out their roles effectively.

Professor George said: "While resources are important, we believe that a change in attitude, rather than additional funding, lies at the heart of developing better training programmes for preregistration house officers." □

The New Doctor is available from the General Medical Council, 178 Great Portland Street, London W1N 6JE.

Young doctors feel isolated

Stephanie Swafford, Clegg scholar, BMJ

Young British doctors are feeling increasingly alienated in the current healthcare system, says a new report. NHS pressures are taking the joy out of medicine and eroding younger doctors' sense of vocation.

The BMA commissioned Isobel Allen, head of social and healthcare studies at the Policy Studies Institute, to meet doctors under 40 and discuss the "core values" of their profession.

The resulting report, *Committed but Critical*, highlights the commitment of young doctors to their patients and outlines areas of concern. "One of the most striking features was the extent to which they felt isolated," said Ms Allen. Often, it is only a strong commitment to their patients that prevents them from leaving medicine altogether.

Doctors said pressures were caused by the managerial culture of the NHS, increasingly intensive work, lack of support from medical and non-medical colleagues, poor working conditions, and inadequate maintenance of equipment. As a result, they fear that patient care is in jeopardy.

Young doctors feel alienated by managers

Managers were seen as a major cause of this alienation. A senior registrar said: "I find it very difficult interacting with managers because their primary concern is not the care of your patients."

The report concludes that doctors feel a perceived loss of autonomy arising from the increasing need to measure and account for their clinical and professional actions. "If somebody else is driving you like a horse, you're not in charge," said a consultant. Ms Allen said: "These young doctors want their professional competence and clinical judgment to be respected. They do not want to be 'technical monkeys.'"

The NHS Confederation, representing health authorities'

interests, attacked the report saying that its criticism of NHS management undermines the team approach being established in many trusts and that junior doctors should follow the example of their more senior colleagues who are involved in trust management. However, Dr Vivienne Nathanson, head of health policy for the BMA, responded that the report was identifying areas where improvements need to be made.

The feeling of isolation was discussed at the BMA's junior members forum in Bournemouth last week. They passed a motion stating: "This meeting believes that the disillusionment of young doctors is so great that industrial action should now be considered." □

Family accuses doctors of failing to warn of risk

Clare Dyer, legal correspondent, *BMJ*

The parents of a boy left severely brain damaged after a heart transplant operation accused doctors in the High Court in London last week of failing to warn them of the risk.

Kevin and Linda Poynter sued Hillingdon Health Authority in west London for damages on behalf of their son, Matthew, now aged 10. They claim that they would never have consented to the operation in 1987, when their son was aged 16 months, if the surgeon, Sir Magdi Yacoub, and his team at Harefield Hospital had told them that there was a risk of brain damage.

Judgment was awaited as the *BMJ* went to press but was due to be delivered last Wednesday. Cases based on failure to warn are legally difficult, and this case raised important issues about how much information doctors are obliged to impart about a proposed course of treatment.

In the leading case, *Sidaway v Bethlem Royal Hospital Governors*, which went to the House of Lords in 1984, an attempt was made to import the American doctrine of informed consent into English law. Under this doctrine a doctor must disclose all material risks—any risks to which a reasonable patient would attach significance in deciding whether to have or forgo the treatment. But the House of Lords in *Sidaway* rejected this.

A majority of the judges held that the so called Bolam test, which decides whether a doctor was negligent in carrying out treatment or performing surgery, also applies to warnings. This means that if a responsible body of practitioners at the time would not have warned of the risk, a doctor who failed to do so would not normally be found negligent. But when there was a “substantial risk of grave adverse

Sir Magdi Yacoub told the court the risk of brain damage was small

consequences,” Lord Bridge said, then the patient had a right to be told.

The judges also said that a patient who asked a direct question should be answered truthfully. The High Court heard last week that Matthew, whose injuries occurred as a result of a cardiac arrest when he was being anaesthetised, was the only one of 268 babies given new hearts at Harefield Hospital to sustain brain damage. Sir Magdi told the judge, Sir Mau-

rice Drake, that the risk was so small that he would not mention it to parents unless specifically asked.

Mr and Mrs Poynter say they felt pressured into agreeing to the operation. Mrs Poynter told the court that Dr Richard Kirk, a former member of the transplant team, had said the hospital would consider seeking a court order if she refused her consent. Dr Kirk denied this, saying that he was “overzealous” if anything in telling parents of the risks. □

AIDS drug trials attacked

Jacqui Wise, *BMJ*

The design of clinical trials for AIDS drug treatments have been sharply criticised by an AIDS researcher.

Joep Lange, from the national AIDS therapy evaluation centre in Amsterdam, says that too often suboptimal drug treatments are still being used, both in the treatment of patients with AIDS and in clinical trials (*Science* 1997;276:548-50). This is partly because regulatory requirements often dictate that data are gathered on single treatments, even though such monotherapy is known to produce drug resistance.

Dr Lange also accuses pharmaceutical companies of sometimes dictating that only their drugs are used in trials of combination treatment, even when data suggest that the particular combination under study is most effective when it includes drugs from another company. “This is wrong and disgraceful,” says Dr

Lange. “If antiretroviral agents are going to be used properly so that HIV infection can be turned into a chronic disease, there is room and need for many drugs on the market.” He says legislation is needed to prevent the exclusive use of incestuous drug combinations in clinical trials.

Another problem is the tendency to publicise rapidly and widely positive data and to delay or not to publish studies with a negative outcome. He calls for a regulatory requirement to publish all relevant data, both positive and negative, within a certain time frame after completion of a trial.

Dr Lange says that so called strategic trials, which ask questions such as when to start treatment, when to change, and when to stop, are “obsolete.”

He says future studies of antiretroviral drugs should include a long follow up period, flexibility with regard to drug regimens, comprehensive sampling from other tissues as well as blood, a strong pharmacology component, and a strong scientific component. “Without a good scientific base it is often better not to do the trial at all,” he says. □

US doctors rush to join unions

Fred B Charatan, *Florida*

Increasing numbers of doctors in the United States are joining unions as a result of the enormous changes that are occurring in the healthcare system. The American Medical Association estimates that of the 720 325 doctors in the US, between 14 000 and 20 000 now belong to one of the eight unions.

“Interest has increased exponentially in the last six months,” said Dr Barry Liebowitz, president of the Doctors Council, representing 3400 doctors, dentists, optometrists, podiatrists, and veterinarians. “Doctors are having gag orders and drive through mastectomies imposed on them. They are finding themselves in an economic morass, where professional control translates into economic control.”

Dr Liebowitz said that it became recognised in the 1980s that if doctors could be controlled huge profits could be

generated in health care. Unions are becoming crucial for negotiating with highly sophisticated and economically powerful employers on behalf of its members.

The Union of American Physicians and Dentists, based in Oakland, California, and founded in 1972, is the nation's largest doctors' union, with 5000 members, a membership rise of 70% since 1992. About 40% are family doctors and 60% are specialists from all over the US, but most are from California. Gary Robinson, the union's executive director, said that when managed care takes over a market, capitation is a byproduct as insurers seek to increase profit by passing risk on to doctors. This trend has led to more doctors turning to unions for support.

The trend towards unionisation is also due to the rise in salaried doctors—now 45.4% of doctors are salaried compared with 32% in 1990. The Federation of Physicians and Dentists, the nation's second largest doctors' union, has seen an increasing number of doctors in private practice join. □