European surveillance network to be set up

Tony Sheldon, *Utrecht*

Dutch health minister Professor Els Borst-Eilers has hailed the unanimous decision to set up a European network for the surveillance of infectious diseases as a "revolution in cooperation" in public health.

Agreement was reached after a lengthy debate at the European Council of Ministers in Luxembourg last week, which was chaired by Professor Borst as part of the Dutch presidency of the European Union.

European ministers also passed a resolution on exchanging information on doctors who are guilty of serious professional misconduct. A health monitoring programme with a budget of Ecu13.8m (£9.6m; \$15.3m) was also finally agreed, as was a request for the

European Commission to agree cross border cooperation to ensure the quality of human organs and tissue.

The network for the epidemiological surveillance and control of infectious diseases aims to help member states of the European Union take suitable health prevention measures by "systematically collecting, analysing, and distributing" health data. A single European infectious diseases institute with its own staff was rejected in favour of a "lighter structure"—a network linking all the established national institutes.

Some member states feared that surveillance could lead to enforced harmonisation of prevention measures against infectious diseases. But the Dutch

health minister sees the network as offering an early warning system for detecting the emergence of new or more resistant infectious diseases.

A resolution following a European Union symposium held in Amsterdam earlier this year was accepted (25 January, p 251). This asks the commission to look at how the exchange of information on professional misconduct can be improved in order to prevent doctors who are no longer allowed to practise in one country setting up practice in another member state.

The resolution also asks the commission to look at how the existing system works and consider possible changes to directive 93/16 covering the free

movement of doctors and recognition of qualifications within the union.

The outstanding commission proposal for a European ban on tobacco advertising remains deadlocked, despite hopes that a Labour government in Britain would reverse the United Kingdom's opposition. In a statement public health minister Tessa Jowell said that the British government shares the draft directives' broad objectives but that "unresolved legal questions" remain about its scope.

She said the scope for action in the European Union would be discussed in the UK after a summit in July of international experts who will examine options for reducing smoking. (See p 1713.) □

Woman asks court for peaceful death

Clare Dyer, *legal correspondent, BMJ*

A woman suffering from motor neurone disease is to ask the High Court for the right to end her life peacefully in the first case of its kind in Britain.

Annie Lindsell, aged 47, wants to die at home and is seeking a guarantee that her GP will lawfully be able to administer enough morphine to ease her distress, even though the dose may be fatal. Her lawyers emphasise that she is not asking for voluntary euthanasia, which is unlawful, but relying on the doctrine of double effect, under which a doctor may administer a drug with the intention of relieving pain, even when death is the probable or inevitable result.

The court will decide for the

first time whether the principle extends to relieving the distress suffered in the final stages of motor neurone disease, when patients become paralysed and unable to speak and usually die from suffocation. Ms Lindsell, whose illness was diagnosed five years ago, wants to go on living while she still has a reasonable quality of life, but she wants to avoid the terminal stage, which she says a friend who died of the disease described as "like being in a coffin."

In an application filed with the High Court last week she is seeking a declaration that her GP "may lawfully administer palliative medicine with the purpose of relieving her distress resulting from the progression of motor neurone disease, although a probable consequence of the administration of such medication may be the shortening of [her] life." In a preliminary hearing set for this week the court was expected to arrange for the appointment of

an *amicus curiae*—an independent lawyer—to advise the court on what is a legal grey area.

The case is likely to be expedited and could go all the way to the House of Lords and possibly to the European Court of Human Rights in Strasbourg. Ms Lindsell said: "The worst thing is the thought of not being able to communicate when the brain is active. I am seeking to ensure that there is no doubt about my terminal palliative care, particularly as I want to die at home."

Her QC, Lord Lester, who was *amicus curiae* in the Tony Bland right to die case, will argue that the double effect applies not just to the relief of pain but to ending the distress suffered in the final stages of illnesses such as motor neurone disease. The House of Lords Select Committee on Medical Ethics, in its 1994 report which recommended retaining the ban on euthanasia, concluded that in some terminal cases it was "wholly acceptable in terms of

Ms Lindsell wishes to die at home

medical practice and under the current law" for doctors to give potentially fatal doses of palliative drugs with the motive of relieving pain and distress and with no intention to kill. □

In brief

United States panel recommends legal ban on human cloning: The National Bioethics Advisory Commission said in its report to the US president, Bill Clinton, that congress should enact a law to prohibit the creation of human beings by cloning. However, the report stopped short of recommending a ban on the creation of cloned human embryos for research purposes—a practice already banned among federally financed researchers but unregulated in the private sector.

British MPs sent pro-tobacco video: An eight minute video has been sent to all MPs to try to persuade them to vote against a ban on tobacco advertising and sponsorship of sport. The video says that it explodes the myth that tobacco advertising increases consumption. Only at the end of the video does it become clear that it has been produced by the Tobacco Manufacturers Association.

Certain specialties at higher risk of suicide: Gynaecologists, psychiatrists, and female anaesthetists are most at risk of dying a traumatic or accidental death, according to a study in *Occupational and Environmental Medicine* (1997;54:388-95). However, overall death rates for doctors were half those of the general population, with low rates of heart disease, lung cancer, and diabetes.

Health managers say rationing is widespread: A survey by the Institute of Health Services Management found that 90% of managers who responded felt that health services in their locality had been subject to rationing, mainly because of financial pressures. Only 12% said that rationing was the result of the evidence based medicine drive.

Silicone breast implant review announced in UK: Roger Sturrock, professor of rheumatology at Glasgow Royal Infirmary, is to chair the independent review team that will examine the evidence relating to possible health risks associated with silicone gel breast implants.

New French government will try to reduce health costs

Alexander Dorozynski, *Paris*

The priority of the new Socialist government in France will be to reduce health costs, with the deficit in the health insurance branch of the social security system expected to reach Fr72bn (£8bn; \$12.8bn) in 1996-7.

The prime minister, Lionel Jospin, promised during his campaign not to reduce the reimbursement of patients' bills, but he remained vague about measures that he might take to balance the health budget. The

most likely solution is to increase the assessment base for national insurance beyond the contribution now limited to employers and employees.

Doctors are concerned about what the new government will do with the most unpopular measure of the "plan Juppé," the health cost control scheme named after the former prime minister, Alain Juppé: financial penalties against doctors who overprescribe. The measure

Dr Bernard Kouchner and Martine Aubry face a tough challenge

helped to rally many doctors against the Conservative government, but now that the Socialists have won there are good reasons to doubt that they will scrap the plan, which is more Socialist than Conservative in its approach.

The new government may or may not cancel this one unpopular measure, but it is unlikely that Martine Aubry, minister of employment and solidarity, will overhaul the Juppé plan, which took two years of effort and survived several strikes by doctors before being grudgingly accepted by at least some of the medical unions.

Neither is it likely that Dr Bernard Kouchner, secretary of state for health in Madame Aubry's ministry, will yield any ground. Minister of health and humanitarian action in 1992-3, he has not hesitated on occasions to criticise the medical profession for its corporatism. During the recent strikes, however, Dr Kouchner voiced his support for negotiations with health professionals rather than measures imposed from the top. "You'll never make a reform in France without the doctors," he has said.

One of the thorniest issues is the reorganisation of public hospitals and the closure of excess beds—a measure that has been generally supported by the Socialists but opposed by their Communist allies. □

US patients can sue HMOs

Fred B Charatan, *Florida*

Texas has become the first United States state to allow patients to sue health maintenance organisations (HMOs) for malpractice.

"The delivery of health care has changed over the past decade," said Dr David Sibley, a doctor and Republican state senator from Waco, who sponsored the new law. "A third party has inserted itself into the treatment room, operation room, and examination room. And I can think of no reason why a doctor should be held accountable for a decision but an HMO should not."

The governor of Texas,

George Bush, said that he would allow the bill to become law without signing it, indicating that he would follow the bill closely.

Managed care companies and business groups agree; they say that the new law could drive up the cost of health insurance premiums by 4.5% to 12%. But consumers, plaintiffs' lawyers, and many doctors claim that insurance companies, in a drive to cut costs, have increasingly interposed themselves in medical decisions by denying, delaying, or reducing treatments. HMOs respond by insisting that they are not in the business of practising medicine, only of administering insurance policies. Legally, they do not make medical decisions but inform consumers and doctors about which procedures they will pay for under their policies.

Mona Taylor, public affairs

director of the Texas HMO Association, pointed out that arguments under the new law might even hold employers liable for medical malpractice claims, if, for example, they chose not to pay their employees' health care policies.

Kim Ross, chief lobbyist for the Texas Medical Association, which strongly supports the bill, said that it would spread the cost of malpractice insurance, putting some of the burden on health insurance companies. Similar measures are pending in other states, including New York, where a bill that would allow patients to recover medical negligence damages from insurance companies is now before the legislature. A similar bill was passed in Florida last year, but the governor, Lawton Chiles, vetoed it, expressing concern over higher costs. □

Canadian GPs retire early to save money

David Spurgeon, *Quebec*

The Canadian province of Quebec will lose an estimated 230 of its most experienced family doctors under an early retirement agreement concluded with the government. The agreement was an alternative to legislation to cut 6% off the province's overall medical budget.

Dr Renald Dutil, president of the *Fédération des Médecins Omnipraticiens du Québec*, called it "the lesser evil" compared with the provisions of Bill 104. Under the scheme doctors aged 50 and over who agree to retire by 1 December will receive settlements based on the mean of their incomes during the past five years.

The amounts are 200% for doctors aged 50 to 64, 150% for those aged 65 to 69, and 100% for those aged 70 and over. The maximum amount will be \$C300 000 (£136 000; \$217 600), which will be paid over a period of four to 10 years. The programme will be financed by

equal contributions from the federation and the government.

To escape the provisions of Bill 104 the family doctors have to save the government a total of \$C50.4m. Other savings will come, for example, from a previous early retirement plan that came into effect on 1 April; voluntary restrictions of doctors' incomes by 5% or 10%, allowing them to charge higher fees for individual services; reductions in hourly pay scales and cuts in statutory holiday pay of slightly more than 12% for those on fixed salaries; and reductions in the ceiling of 50 examinations a day, with reduced pay for extra visits.

Dr Dutil acknowledged that these measures would "have the effect of temporarily restricting access to the services of GPs in some areas, but we hope that the arrival of new physicians and better manpower allocation will rectify this situation."

Some gains were made in the federation's negotiations, Dr Dutil said. These included recognition by the government of doctors' operating costs and the allocation of \$C8m for 1997-8. The health ministry also agreed to include reimbursement by Medicare of services to certain groups of people. □

Suicide hotline to be set up for Australian doctors

Christopher Zinn, *Sydney*

A special hotline to help doctors at risk of committing suicide is a priority recommendation in a damning report into Australian doctors' mental health.

The joint report, from the New South Wales Department of Health and the state's branch of the Australian Medical Association, found that 21 known suicides since 1992 were only the "tip of the iceberg."

It said that in New South Wales doctors were 50% more likely to kill themselves than the rest of the population. Women doctors, young doctors, and resident medical officers in the public hospital system were at greatest risk.

The state's health minister, Dr Andrew Refshauge, endorsed three of the report's key recommendations as priorities. As well as the hotline, the recommendations include a "healthy hospital scheme" to educate staff about mental health and support for those affected by the suicide of a colleague. "Doctors are no different. But doctors also have a

very stressful job, often making life and death decisions and are often expected not to complain and not to seek help themselves," said Dr Refshauge.

The report of the working group also found that most doctors do not have a GP, and the Australian Medical Association is now pushing for every doctor to be registered with one by the end of this year.

The report also blamed the extra stress that some doctors felt on the "authoritarian hierarchies" of hospitals. Other factors included threats of litigation; more patients' rights; increased isolation; uncertainty about future career options; and the perception that the medical profession is in decline.

Professor Beverly Raphael, chair of the doctors' mental health working group, said that there was no single cause for the high suicide rate, but doctors were much less likely to seek help. "They are afraid someone will know about it, and they feel they are letting the side down." □

Israeli plans to sue tobacco companies

Judy Siegel-Itzkovich, *Jerusalem*

Israel is the first country outside the United States to sue tobacco manufacturers to help cover the medical costs of treating people with smoking related diseases.

The deputy health minister, Shlomo Benizri, told the Israeli parliament on World No Tobacco Day on 31 May that the government had decided in principle to launch a 20bn shekel (£3.57bn; \$5.71bn) lawsuit against the companies. Dubek, the cigarette manufacturer and importer, refused to comment on the news.

On average 15 Israelis die each day from tobacco related diseases; at an annual death rate of about 5500, this number represents more than all of Israel's victims of war, terrorism, and

road accidents combined. An estimated 400 000 working days are lost each year from smoking related diseases, and the annual costs are estimated to be \$3bn.

Israeli antismoking activists said that they hoped that their European counterparts would launch similar efforts in their own courts. Although the exact timing and form has not yet been determined, ministry officials will model the lawsuit on the one that over 20 US states are taking out against American tobacco companies (26 April, p 1217). Antismoking activists have consulted Minnesota's attorney general, Hubert H Humphrey III, a prime mover behind his state's lawsuit.

The minister said that other steps contemplated included the strict regulation of tobacco advertising; prohibition of the sale of cigarettes to minors; a ban on cigarette vending machines; and a rise in cigarette prices. The proceeds would be used to finance information campaigns and enforce the new restrictions.

On average 15 Israelis die every day from tobacco related illnesses

Until now, the government has opposed a dedicated tax on cigarettes that would be spent specifically on the discouragement of smoking; it has also claimed that raising cigarette prices too high would encourage cigarette smuggling from the Palestinian territories.

The Knesset, which a few years ago passed a law restricting smoking in all workplaces, is still known for its smoke filled rooms. The speaker, Dan Tichon, has instructed that anyone caught smoking in a no smoking area should be fined 180 shekels (£32). □

The German medical association held its 100th annual conference in Eisenach (in the former East Germany) two weeks ago. Sandra Goldbeck-Wood reports.

Germany to reform GP training

The German medical association has agreed radical changes to GP training—from 2005, GPs will need to train for five years rather than the current three after registration.

Up to three years of this lengthened training may be spent in general practice, with one and a half years as a minimum. Trainees will also spend at least a year in internal medicine and six months each in child health and surgery. The remaining two years can be spent in a series of optional specialties, both in hospitals and in office based practices.

The reforms are intended to boost flagging public confidence in GPs, according to Professor Jörg Hoppe, vice president of the German medical association, who chaired the committee responsible for the new proposals. "This decision will guarantee a very high standard of primary health care and raise the status of GPs in relation to other specialists. We want to encourage young doctors to consider general practice as a career," he said.

The move is also seen as a means of warding off competition from non-medical therapists: "This should reverse the trend towards therapies not based in science which is spreading within our country at the moment," said Professor Hoppe.

The new training requirements, which have been opposed vehemently by junior hospital doctors' representatives, will not be implemented until well into the new millennium, when detailed financial plans have been agreed with health insurance companies and the German hospitals' association.

Dr Ulrich Montgomery, president of the Marburger Bund, which represents junior hospital doctors, believes this can never be achieved. "It is absolutely unclear who is going to pay for these extra posts ... Postgraduate training has never been separately funded in Germany; it's considered a byproduct of employment. This change will require massive funding—for example, from hospitals or insurance companies—and it's quite naive to believe that they will be prepared to contribute to the costs of training without requiring some influence over its content." He believes such an influence would be intolerable: "It would be like the British department of health controlling matters of postgraduate medical education instead of the royal colleges," he said.

The change occurs at a time when hospital beds are closing as more treatments are carried out on an outpatient basis and when around 11 000 doctors, predominantly from the hospital sector, are registered unemployed. Dr Montgomery said: "It is hard enough for juniors to find jobs as it is without lengthening their training by two years.

JOHANNES AEFERMANN

Professor Hoppe, President Herzog, and Dr Villmar

This will make it harder, not easier, to persuade doctors to train in general practice."

The decision will not affect doctors currently working in general practice. Of those currently practising, some have received three years of postgraduate training in general practice, some have been trained in allied specialties such as internal medicine, and some, who qualified before 1990, have received no formal postgraduate training at all.

Despite this clear commitment to promoting general practice, the German medical association denies any intention of moving towards a gatekeeper system analogous to that in Britain. Instead, German citizens currently hold a kind of smart card entitling them to consult any specialist of their choice at any time.

Dr Karsten Villmar, the association's president, said: "We have no use for a primary health

care system here, and it is not our intention to introduce one. We have different and better structures. We have unparalleled access to high quality health care, and we would not wish to compromise that."

Professor Hoppe agreed: "The free choice of doctors has a long tradition in Germany and should not be limited. However, we do want to encourage the public to consult GPs as a first point of contact." Professor Hoppe acknowledged that the association hoped this would reduce unnecessary costs such as those arising from duplicate investigation. However, he denied that cost cutting was a primary motivation in the decision. "We have now given the public a clear signal of where we believe health care in Germany should go. But there can be no question of coercive measures," he said. □

Personal responsibility, not rationing, is the way forward

Germany's president, Dr Roman Herzog, called for more personal responsibility on the part of patients and more care with scarce resources at the 100th annual congress of the German medical association last week.

Speaking at the conference's opening ceremony, Dr Herzog criticised the "free lunch" mentality of some patients, saying: "We are each responsible for our own health. A healthcare system based on social solidarity cannot

exempt individuals from playing their part."

Addressing the question of resource allocation, Dr Herzog said: "Health insurance is for the medically necessary, not for everything which might be socially or politically desirable." His comments follow more than two years of reforms to the German health system, during which many services previously available on health insurance, such as attendance at health

spas, have been withdrawn. In other areas the proportion of costs to be shared by the patient has been increased, such as the cost of prescriptions, spectacles, and stays in hospital.

However, rationing is not on the agenda, according to health minister Horst Seehofer. He said: "We believe that whatever is truly necessary must be afforded. If elderly people can be given a treatment which will allow them to breathe a little easier while climbing the stairs, we must provide this without reference to the cost."

Asked whether even "necessary" treatments might need to

be rationed, Dr Seehofer replied: "This is a discussion we cannot have in Germany."

The association's anniversary congress took place in Eisenach, which first hosted the congress in 1874. The small town, better known for its connections with Bach and Luther, has seen more doctors' congresses than any other in Germany but has been inaccessible for 40 years in the former German Democratic Republic. The German medical association, formed in 1871, officially readmitted colleagues from the former East Germany in 1991. □

Dutch presidency has seen a quiet revolution in public health

Professor Els Borst-Eilers has come to the end of her six month term as Dutch president of the European Union. She tells Tony Sheldon that she feels important steps have been achieved.

Professor Borst has had a varied career in medicine

Dutch health minister Professor Els Borst-Eilers decided to become a doctor as a child while enduring the Nazi occupation of Amsterdam. A doctor, she thought, would be useful in the "next" war.

Her background in medicine has proved to be more than useful. Last week in Luxembourg she chaired the European Union's Council of Health Ministers as part of a Dutch presidency that has witnessed a quiet revolution in the union's role in public health. Under her leadership work will now begin in areas such as health monitoring, surveillance of infectious diseases, and professional standards for migrating doctors.

Ministers met against a backdrop of the bovine spongiform encephalopathy (BSE) crisis, which resulted in a revamped health role for the European Commission with the launch of

Emma Bonino's consumer policy and health protection unit alongside the public health responsibilities of Padraig Flynn.

Professor Borst may be unique among health ministers as she has had a career as a doc-

■ *"I should try to do everything in my power to prevent people from starting to smoke"*

tor, health academic, hospital medical director, and government scientific adviser. She graduated in medicine in 1958 and studied paediatrics before following an academic career in immunology. She then entered hospital management as director of Utrecht University Hospital's bloodbank before a 10 year stint as medical director. From 1986 to 1994 she was deputy chair of the Dutch Health Council, a government advisory body.

Three years ago, at the age of

62, she "reluctantly" accepted the post of health minister. She now says it is the best job she has ever had. Professor Borst's political and medical experience will be brought to bear this weekend at the intergovernmental conference in Amsterdam in backing the Dutch proposal to rewrite the Maastricht treaty's article 129 in order to give a sharper focus to the European Union's legal competence to act on public health.

Professor Borst does not see far reaching changes but argues that the treaty needs to be extended and made more explicit in the light of the dramas over BSE in Germany. The Dutch propose setting "minimum requirements" for quality and safety.

"It is good to look where you can have added value from community action. The first thing that comes to mind is where there is cross border exchange—blood products, organs, the import and export of food—things where the health of the population could be in danger if another member state is careless."

Professor Borst has also launched a debate on the principles and priorities underlying the new framework for public health that will take European policy into the 21st century. She sees "absolute limitations" on what the union can achieve. But she sees two important questions emerging: How can consumers be protected against unsafe imports? And will patients move more freely across European borders in search of treatment?

"It amazes me that so few patients on waiting lists try to seek help in another member state," said Professor Borst. She said that member states could

refuse to treat each other's patients, but that may contravene human rights or union regulations on the free movement of goods and services. "I don't see a solution, but it is something we will have to discuss and decide how to deal with it because patients will discover these routes sooner or later."

Agreement has now been reached on a European Union monitoring programme that will mean a uniform handling of data and criteria for diagnoses

across the union. Professor Borst argues that the union will now be able to identify common problems better—for example, the third most common cause of death today is cerebrovascular accidents or strokes. Research and funds can then be steered towards these problems.

Professor Borst has also succeeded in her determination to begin work on a union network for epidemiological surveillance of infectious diseases after finally gaining unanimous support last week. She explained that some member states were opposed to the move, fearing that it could mean a harmonisation of measures to combat infectious diseases such as restrictions on travel for people testing positive.

"There was a lot of misunderstanding about harmonisation. That word harmonisation makes people's hair stand on end," she said. She explained that the network would simply monitor the prevalence of diseases and give early warning of the emergence of a dangerous infectious disease, a new resistant strain, or an entirely new disease. If detected early enough then the focus of infection could be contained.

Another area where a degree of European cooperation has been agreed is with doctors' professional misconduct. A system of "actively communicating information" between member states on doctors who have been struck off their own country's medical register is planned.

The commission's long standing proposal to ban tobacco advertising has made no further progress, but the position of Professor Borst is clear. Whereas the Dutch cabinet is committed to industry self regulation, she would support a ban.

"Cigarette smoking is the first cause of preventable death, so as a minister of health I should try to do everything in my power to prevent people from starting to smoke." She is convinced that advertising does have an influence and that, whereas self regulation is a nice idea, "the primary goal of the tobacco industry is to sell tobacco products."

In her address to the European parliament Professor Borst insisted health must remain part of the vision of tomorrow's Europe. Her assessment of the Dutch presidency is that it may not have been a "revolution" but "important steps" have been taken. □

BMA rules out move to "super hospitals"

Linda Beecham, *BMJ*

The leader of Britain's hospital consultants has warned that moves to build "super hospitals" serving large populations would be disastrous and would not save money and that any radical reorganisation of the hospital service would need careful strategic planning.

The drive towards greater specialisation seems to favour larger hospitals and it has been suggested this would save money and achieve better clinical results. Speaking at last week's senior hospital staffs conference, the chairman of the Central Consultants and Specialists Committee, Mr James Johnson, admitted that some factors seemed to favour a change. Small to medium sized district general hospitals found it difficult to provide emergency cover.

There were often shortages of consultants in key specialties, and it could be difficult to provide reasonable on call rotas for consultants and junior doctors.

However, he said that the evidence was conflicting on whether bigger units treating greater numbers of patients achieved better clinical results. The York Centre for Dissemination of Health Outcomes had shown that for most of over 30 conditions which it had studied there was no evidence of a volume effect.

At the CCSC's request the BMA's research unit studied alternative structures for delivering hospital services. Using real data from one health region with 10 trust hospitals, some on multiple and split sites, it produced three models to serve a population of two million. The first one was for one super hospital with 6000 beds, which was dismissed as unworkable. In the second model the largest hospital in the region was expanded with a few peripheral hospitals. In the third model the number of hospitals was reduced to

eight, all the split sites were removed, and accident and emergency services were provided in only five of the trusts. Such a model, Mr Johnson said, would be feasible but "the political consequences would be considerable." And it was uncertain whether it would save money or improve services for patients.

The conference said that district general hospitals provided

an unrivalled service; it supported the comprehensive nature of their services and said that any central specialist services should be based on sound medical evidence. The local impact of a very large hospital, the availability of non-medical people to staff it, and its accessibility should be taken into account when deciding the future size of hospitals. (See p 1768.) □

CHARLES MULLIGAN

Mr James Johnson said that bigger is not always better

Focus: Washington

Coincidental politics

John Roberts

President Clinton and the Republican Congress are still publicly congratulating themselves on reaching agreement earlier this year to balance the US government budget by 2002. But behind closed doors there are already shortening as the work begins.

There is no more fractious a spending topic than Medicare, the government programme to insure the elderly, which is also America's single biggest health insurance plan. The budget agreement calls for the programme, which has grown almost 200% over the past 10 years, to be cut by 8.5% over the next five. That means cuts of \$115bn (£70bn).

The economics are simple. Everyone employed in the health sector will lose some,

and some will lose a lot. So the queue of special interests is growing rapidly. They include representatives of the elderly, the hospitals (who account for 50% of spending), doctors (15%), home health agencies (9%), nursing homes (6%), health maintenance organisations (12%), and others.

At the same time, the Republicans have pulled out an old issue, abortion. A bill is now moving through congress that would ban "partial birth abortion" (31 May, p 1572).

At the crossroads of these two high profile political issues comes the American Medical Association. Unlike the BMA, the group does not represent most doctors and is not a labour union, but, like the BMA, it is one of the strongest lobbies. The AMA represents many things, but "physician autonomy" has always been its banner phrase. Because of this, it has never commented strongly on the abortion issue that has divided America for more than a quarter of a

century. Until now.

In mid-May, when the AMA announced its support for a ban on third trimester abortions, at the same time (but coincidentally, it says) it sent a letter to house speaker Newt Gingrich that outlined what it hopes to maintain from the Medicare budget cuts. The AMA and Republican leaders say the two issues are unrelated. Pundits and Democrats who know the AMA are sceptical, at best. California Democratic congressman Pete Stark told *Modern Healthcare* magazine, "It seems a little out of character for [the AMA] to deal with a specific practice. Their issue is, 'Let the doctor decide.'"

The AMA's letter, from executive vice president P John Seward, focused on physicians' fees, requesting that cuts in specialist and surgical fees should be phased in slowly. A fairly well agreed on formula now calls for cuts in surgical fees of 9.4% in the next year alone. The letter also asked for

a delay in a reformulation of coverage for practice expenses that would penalise surgeons and specialists relative to primary care doctors.

The AMA has been embarrassed in the past in attempts to trade favours with politicians. The most notorious incident was during the debate to create Medicare in the 1960s: the AMA agreed to remain quiet about tobacco's dangers in order to try to kill Medicare. Obviously, it failed to stop Medicare, and it has since become a leader in the antitobacco movement.

Oddly, it was an AMA sponsored newspaper that reignited the debate over third trimester abortion in March. *American Medical News* published an interview with an antiabortion lobbyist who said that pro-abortion advocates had lied when they provided estimates of the incidence of late term abortions to congress. That charge was sustained, which angered Republicans enough to reintroduce the bill.