Guidelines warn psychiatrists about memory recovery techniques

Daloni Carlisle, *London*

Psychiatrists in Britain have been advised not to use "memory recovery techniques" to unearth past sexual abuse of which the patient has no memory. But the Royal College of Psychiatrists has pulled back from publishing the report on which its new guidelines are based.

The guidelines follow concern over the "false memory syndrome," in which patients recover memories of childhood sexual abuse under techniques such as hypnotherapy, regression therapy, and drug mediated interviews. The college says that these techniques are not acceptable in psychiatric practice, that they are unproved, and that an increase in litigation against alleged perpetrators and therapists risks bringing the profession into disrepute. Psychiatrists should never use forceful or persuasive interviewing.

But the report on which the guidelines are based has proved too controversial for the college to publish. Instead, it will be published under the authorship of

the individuals who wrote it, probably early next year. Professor Sydney Brandon, who convened the college's working party, said: "It became clear very early on that there was a great deal of discontent that we were even considering the matter. There was thought to be insufficient scientific evidence and room for wide differences of opinion, and any view we developed was likely to cast doubts on the reality of child sexual abuse." He added: "We came to the conclusion that the safest thing to do was to come up with some clear and unequivocal guidelines condemning certain practices."

The report was prompted by a longstanding row in the United States in which psychiatrists and therapists have been unable to agree on the false memory syndrome. Professor Brandon said: "Despite the groups who insist there is no such thing as a false memory we came to the conclusion that they can be created. This is all the more likely in circumstances where the therapist

starts with the belief that all adult relationship problems are related to childhood memories of abuse."

One of the main concerns about publishing the report was that it would be used to deny the reality of child sexual abuse. Professor Brandon said he had already been approached by lawyers to testify that the memories of a 14 year old were false,

which he was not prepared to do.

Simon Wessley, professor of epidemiological psychiatry at King's College, London, said that most psychiatrists now agree that false memories could be created by "overzealous" therapists, but that not all recovered memories were by definition false. "People have taken an all or nothing position, and this is clearly absurd." □

Psychiatrists have been warned against forceful interviewing

BMA calls for changes to legal aid system

Clare Dyer, *legal correspondent, BMJ*

The BMA and the three medical defence bodies in Britain are so concerned about the rising cost of litigation that they are urging the government to make it harder for people to get legal aid to sue doctors and NHS trusts.

Dr Mac Armstrong, secretary of the BMA, wrote this week to the Lord Chancellor, Lord Irvine of Lairg, after receiving no reply to an earlier letter to Sir Tim Chessells, chairman of the

Legal Aid Board. That letter, sent in July, was signed by Dr Armstrong and the chief executives of the Medical Defence Union, Medical Protection Society, and Medical and Dental Defence Union of Scotland.

The four organisations are calling for a change in the "merits" test for granting legal aid. They believe that too many hopeless cases are being funded, draining millions of pounds from patient care without producing any benefit for the litigant, whose case is doomed to fail. They also argue that the inability of trusts to get costs from the Legal Aid Fund, even if they successfully defend a case, places a huge financial burden on the NHS. Dr Armstrong said: "This is money

for patients' care which is going into lawyers' pockets. When trusts finally win cases, the litigant is legally aided but the trusts are not, so they're bearing the costs."

The concerns of the BMA seem to be borne out by the low success rate for medical negligence cases compared with other types of personal injury cases. Figures from the Legal Aid Board show that of 12 576 legally aided medical negligence cases closed in the financial year ending March 1996, only 2171 (17%) were recorded as successful. Other personal injury cases, including road and work accidents, have a success rate of about 85-90%.

Labour's plans for radical reforms of the legal aid system, to be unveiled by the Lord Chancellor

next week, could have a significant impact on medical negligence litigation. Lord Irvine plans a big expansion of "no win, no fee" litigation, with lawyers bearing the risk rather than the state. The government wants to replace legal aid with these "conditional fee" arrangements wherever feasible. In medical negligence cases, however, the cost of insuring against losing and having to pay the winning side's costs is high—around £1500 (\$2400). The alternative is to have block contracts under which the state would pay solicitors an overall sum to handle a certain number of cases. These are likely to be restricted to firms with proved expertise, which should reduce the number of hopeless cases brought. □

In brief

American biochemist wins Nobel prize:

Professor Stanley Prusiner from the University of California in San Francisco won this year's Nobel prize for medicine for his discovery of prions, thought to be the infectious agent in Creutzfeldt-Jakob disease. His research could lead to new treatments for dementia related diseases, including Alzheimer's and Parkinson's diseases.

No ceiling set for food irradiation:

The World Health Organisation has said that, from the scientific point of view, there need be no limit to the amount of radiation used to destroy harmful micro-organisms in food.

Smoking among schoolchildren rises:

Latest figures from the Office for National Statistics show that in 1996 in England 15% of girls and 11% of boys aged 11-15 smoked; in Scotland 14% of 12-15 year olds smoked.

US trial of St John's wort announced:

The National Institutes of Health have launched the first trial in the United States of St John's wort a herb that is widely used in Europe to treat depression. The randomised controlled trial will compare St John's wort, with a selective serotonin reuptake inhibitor and placebo. Last year a meta-analysis concluded that the herb may be useful in cases of mild to moderate depression (*BMJ* 1996;313:253).

Japan bans television advertising of tobacco:

Tobacco companies in Japan are to impose a voluntary ban on advertising on television and radio, in cinemas, and on the internet from next April. The Tobacco Institute of Japan also announced that it will end the distribution of free sample packs of cigarettes.

Florida to fingerprint doctors:

From this month doctors in Florida will have to undergo fingerprinting and criminal checks to obtain or renew their medical licence. The move is in response to the growth in fraud involving false medical claims to Medicaid.

US doctors and nurses clash over roles

Fred B Charatan, *Florida*

A group of nurse practitioners opened a primary care practice in Manhattan last month, inflaming a longstanding conflict over the clinical role of different health professionals.

The four nurses in the practice, who diagnose and treat common ailments, are accredited as primary care providers by several big health maintenance organisations. They will receive the same managed care rates—\$50-\$60 (£31-£37) per visit—as primary care doctors. The practice is under the auspices of the Columbia University School of Nursing, which will measure

outcomes and cost per patient over a year. News of the move prompted a heated debate in the letters pages of the *New York Times* last week.

Nurse practitioners are the elite of registered nurses, receiving their licences after two years of graduate training, and they often have a master's degree. They are not required to collaborate with or be supervised by doctors in 26 American states and may prescribe treatment without a doctor's involvement in 18 states.

Linda Pearson, a nurse practitioner and editor in chief of

Nurse-Practitioner Journal, said that there are about 40 000 such nurses in the United States. She estimated that there are 26 000 nurse practitioners who work independently, and the numbers are growing.

Sara Foer, a spokeswoman for the American Nurses Association, said that her organisation supported independent nursing practice and would like to see all nurse practitioners paid at the same rate as doctors. She said a study in 1993 showed that nurse practitioners spent more time with patients than doctors.

The American Medical Association's policy is "to oppose any attempt at empowering non-physicians to become unsupervised primary medical care providers and be directly reimbursed for case management activities."

Dr Charles Aswad, executive vice president of the Medical Society of the State of New York, said that he strongly supported the AMA's policy. He said that Manhattan's nurse practitioner programme violated the law in New York state, which requires a written plan of collaboration between each nurse practitioner and an involved doctor. "The public has a right to ask for a real doctor. We think the public has to be protected from the representation that a nurse clinician is equivalent in training to a physician," he said. □

Nurses are increasingly having more autonomy

London councils fail asylum seekers

Jacqui Wise, *BMJ*

The care of people seeking asylum in Britain is a lottery, with some councils providing a much fairer deal than others, according to a survey of local councils in London.

The Medical Foundation for the Care of Victims of Torture examined the provision of care for asylum seekers in each of London's 32 boroughs and the Corporation of London, which between them care for 15 000 asylum seekers. A year ago welfare benefits were withdrawn from asylum seekers, with the burden of caring for them being shifted on to local councils. Last

October a legal judgment ruled that local authorities had a duty to make arrangements to provide food, shelter, and the basics of life—but "for nothing else."

The foundation's report, *Past Misery, Present Muddle*, said that the overall impression is one of chaos and confusion, with many councils unsure how to interpret the law and how far their responsibilities reach. As a result many asylum seekers are falling through the net and experiencing hardship.

The report highlights the examples of a victim of torture from Turkey who has to walk three miles a day for kidney dialysis and a disabled Eritrean who uses crutches and has to regularly travel for an hour by underground train to buy his groceries because he cannot spend his food vouchers locally.

Helen Barber, the foundation's director, said: "Our

patients have suffered severe torture abroad and are now suffering the further indignity of not being able to support themselves or their families. Many of them are depressed, some to the point of suicide. We call on the government to restore benefits and dignity to all asylum seekers."

The report says that grants from the Department of Health to London boroughs to provide for asylum seekers account for only half the costs needed. It also says there is inbuilt inefficiency in replicating a service across many local authorities that could be managed better centrally. "Asylum seekers' provision depends now on which local authority they live in. Councils are forced to accept responsibility for a national obligation without adequate national funding and to create a series of ad hoc responses to a situation they did not create and cannot control." □

New neonatal screen will pick up 15 more diseases

Zosia Kmietowicz, London

A new technique that allows newborn babies to be screened for a battery of metabolic diseases could be introduced in Britain within the next five years. Tandem mass spectrometry could increase the number of diseases for which babies are tested in the first few weeks of life from just two as at present (phenylketonuria and hypothyroidism) to at least 17, so saving thousands of lives and reducing disability.

Although the introduction of tandem mass spectrometry would entail an initial outlay for machinery, the test would require no extra labour for sample collection—the single dried blood spot currently obtained routinely by health visitors on Guthrie cards is sufficient for the multiple analysis.

The National Screening Committee is currently considering a report on neonatal screening for metabolic disorders commissioned as part of the NHS's health technology assessment programme (*Health Technology Assessment* 1997;1(7)). In it, experts in neonatal screening conclude that there seems to

be a strong case for introducing tandem mass spectrometry.

Dr Rodney Pollitt, director of Trent's neonatal metabolic screening programme and lead author of the report, believes that the committee will advise that a pilot study of the new screening technique is performed before recommending a nationwide service.

"We are suggesting a three year pilot study, which we hope to start next year, and as long as the results are favourable, more general tandem mass spectrometry could be introduced soon afterwards," said Dr Pollitt.

The new screening programme would include a test for medium-chain acyl coenzyme A dehydrogenase deficiency, which is associated with sudden death in infancy in a quarter of those affected and with disability in many of the survivors. Once diagnosed, however, the disorder is easy to treat by ensuring babies get regular feeds, especially when they are ill.

The screen will also pick up maple syrup urine disease—a condition associated with death,

The multiple screen could be part of the Guthrie test

neurological damage, mental retardation, spasticity, and blindness if left untreated. For some conditions, such as severe forms of glutaric aciduria type II, no cure exists.

Although theoretically a condition that is screened for must have a cure, this is not the case for children, said Dr Pollitt. "These tests are still useful because we can advise couples to seek prenatal diagnosis and have genetic counselling—often if we know that there is going to be a problem from birth then we can do something about it. It is in the

time when diagnosis has not been made that these infants die and are damaged," he explained. "By having these screening tests it means we are presenting children to paediatricians before they are damaged."

The cost of switching to tandem mass spectrometry is estimated to be £0.60 (\$0.96) per baby. The technique would pick up an additional 20 cases per 100 000 infants screened. The laboratory costs for each diagnosis would be about £3000, which Dr Pollitt said is relatively cheap. □

Call for routine cystic fibrosis screening

Zosia Kmietowicz, London

A specialist group has called for more health authorities in Britain to consider testing newborn babies for cystic fibrosis. The call comes as more evidence of the benefits of early diagnosis has emerged from a large study in the United States.

Over 650 000 newborn babies were screened for cystic fibrosis in a trial carried out by the Wisconsin Cystic Fibrosis Neonatal Screening Study Group, but only half of them were given the sweat test to confirm the disease—the rest were diagnosed by standard methods (symptoms, family history).

The investigators found that cystic fibrosis was diagnosed

much earlier with screening—at age 3 months compared with 18 months. Children given the sweat test matched charts showing recommended height and weight for age better than controls at the time of diagnosis and throughout the 10 year follow up because they had not become malnourished in their early life. All patients were given high calorie diets, pancreatic enzyme treatment, and fat soluble vitamin supplements as they needed them (*New England Journal of Medicine* 1997;37:963-9).

The researchers conclude that neonatal screening for cystic fibrosis can prevent malnutrition in infants, leading to more normal growth in childhood with potential long term benefits on lung function. They add that so far no long term risks of screening have been identified and that it is no more expensive to diagnose cystic fibrosis by screening than by clinical methods.

In an accompanying editorial,

specialists from the Netherlands conclude: "Many objections against routine screening that were justified in 1983 have gradually disappeared, as the evidence has accumulated that early diagnosis and treatment are beneficial and that screening probably saves money and carries no harm of its own."

Neonatal screening for cystic fibrosis is carried out in five areas in Britain—East Anglia, Trent, Northamptonshire, Wales, and Leeds, covering about 16% of all births. The Cystic Fibrosis Trust believes that cystic fibrosis conforms to the World Health Organisation's criteria for screening for genetic disease and that testing should be nationwide.

Dr Rodney Pollitt, director of Trent's neonatal metabolic screening programme, has been screening for cystic fibrosis for eight years. In a report on neonatal screening for metabolic disorders commissioned as

part of the NHS's health technology assessment programme, Dr Pollitt and his coauthors conclude that wider screening for cystic fibrosis in infancy should be encouraged.

There are problems with the test, admits Dr Pollitt. About 10% of cases are missed, the test is not very good at pinpointing pancreatic dysfunction, and it picks up cystic fibrosis carriers, which means that these people are sent for genetic counselling without requesting it. But overall the benefits of screening outweigh the drawbacks.

"I started off very sceptically about cystic fibrosis screening, but the more we see parents and children, we know we are doing good. All paediatricians who are involved in the system feel that screening is a great advance. Indications are that it can improve life expectancy by slowing down the disease, and it certainly saves parents a lot of anguish," said Dr Pollitt. □

HIV treatment in children brought into line with that in adults

Deborah Josefson, *San Francisco*

The treatment of children with AIDS should be brought into line with that of adults, according to new draft guidelines from the United States's Department of Health and Human Services.

Historically, because of toxicity and dosage concerns, children with AIDS have been denied the potent drugs routinely prescribed to adults with AIDS. Consensus has been growing that this relative neglect is unfair, especially with the advent of triple therapy with antiretrovirals and protease inhibitors that can lower viral loads to undetectable levels.

Most children acquire HIV during the perinatal period, a time when an infant's immune system is still developing. Maternal antibodies may provide a modicum of protection for the first few months of life, but these wane by 6 months of age, when the infant's immune system becomes wholly responsible for mounting a response. Consequently, the manifestations and progression of the disease in children are variable. However, AIDS is believed to be more aggressive in children than in adults, with viral loads remain-

ing persistently raised for longer periods in the paediatric population than in adults. Children, then, potentially have the most to gain from early treatment.

The recommendations, which were developed by 64 specialists in paediatric HIV care, call for the early diagnosis of HIV infection in children and the rapid start of antiretroviral treatment. Towards this end, they urge the identification of HIV infected women before or during pregnancy and the diagnosis of the disease in babies by 6 months of age. Most cases can be conclusively diagnosed by age 1 month by using sensitive viral tests, while virtually all are diagnosable by 6 months. The new guidelines recommend starting combination antiretroviral therapy in all infants with confirmed HIV infection under 12 months of age.

Susan DeLaurentis, one of the founders of the Paediatric AIDS Foundation, said: "We are glad that these guidelines provide the tools that are urgently needed to bring kids into modern therapy. The disease works faster and is more aggressive in children than in adults and we

REX FEATURES

AIDS is believed to be more aggressive in children than adults

look forward to seeing updated, more aggressive guidelines."

While antiretrovirals and protease inhibitors have been extensively tested in adults, clinical data in children are scanty. Protease inhibitors were approved for use in children aged 2-12 years only seven months ago in the United States and have yet to be approved in children aged under 2. The guidelines contain notes of caution when using these treatments in infants, because of the lack of clinical data. In children aged 2-16 years the side effects

mirror those seen in adults.

The framework for treating children with HIV infection follows recent efforts by the White House and the Food and Drug Administration to open up drug trials to women and children to eliminate guess work on dosage and the use of drugs outside their licensed indications (23 August, p 445).

The public will have 30 days to comment, and the final version of the guidelines will be published in a future edition of the *Morbidity and Mortality Weekly Report*. □

Radiotherapy plus chemotherapy is best for breast cancer

Jacqui Wise, *BMJ*

Women with breast cancer who are treated with adjuvant chemotherapy survive significantly longer if they also receive radiation treatment, according to the 15 year results from two prospective, randomised controlled trials.

The two trials from Denmark and Canada examined whether the addition of radiation treatment to the chest wall and regional lymph nodes increased survival in premenopausal women who underwent modified radical mastectomy and received adjuvant chemotherapy. The results of both trials are strongly positive. The Danish trial shows an overall survival of 54% at 10 years in the group receiving

radiotherapy plus chemotherapy, compared with 45% in the group treated only with chemotherapy (*New England Journal of Medicine* 1997;337:949-55). In the Canadian study the relative risk of dying of breast cancer at 15 years was reduced by nearly one third when chemotherapy was compared with chemotherapy plus radiation (*New England Journal of Medicine* 1997;337:956-62).

Both studies were restricted to patients with a high risk of residual disease—those with involved axillary lymph nodes or regional recurrence. The overall likelihood of local or regional recurrence was 32% in the Danish study, which decreased to 9% when radiotherapy was added.

The smaller Canadian study produced closely similar results with local or regional recurrence in one third of patients with chemotherapy alone, which decreased to 10% with radiation plus chemotherapy.

Dr Samuel Hellman from the University of Chicago said: "The two studies suggest that all patients with positive nodes treated by mastectomy should have radiation therapy to the chest wall and internal mammary nodes. The treatment of the supraclavicular area and upper axilla would depend on the amount of nodal disease found and the extent of the axillary surgery. I believe that similar treatment should be used in patients who undergo breast conservation surgery."

Dr Hellman points out that the management of breast cancer has changed since these two trials started—because of more extensive screening mammography, patients tend to present

with smaller tumours and less axillary node involvement. Both these new trials, however, suggest that the treatment is effective in T1 tumours (<20 mm) as well as in T2 tumours (20-50 mm), although the data were not analysed according to tumour size. Dr Hellman said that if women with a small tumour and negative nodes received adjuvant chemotherapy the treatment should also include local and regional irradiation.

One theory to explain the reduced mortality when radiation is added to chemotherapy is that chemotherapy may eliminate distant micrometastases but be less effective against local and regional diseases that are the source of subsequent fatal metastases. Another possibility is that eliminating the bulky disease with radiation may make the chemotherapy more effective because the overall disease burden is low. □

BMA examines options for funding the NHS

Linda Beecham, *BMJ*

Charges for patients, more private insurance, and a move to a system based on social insurance could all generate additional funds for the NHS, the BMA suggests in a new examination of financing. And it warns that charges might be needed if the additional money—estimated by the association to be £1.5bn-£2bn (\$2.4bn-\$3.2bn) a year over the next four years—is not forthcoming.

At present the BMA's policy is against charges, and the association believes that the financial needs of the NHS are best met from public funding, but because taxation and prescription charges produce insufficient funds, this year's annual meeting called for a re-examination of additional methods of financing (12 July, p 128).

In *Options for Funding Health Care*, which its council approved last week, the BMA estimates

that an across the board fee of £2.50 for a GP consultation would generate £830m; a fee of £10 would bring in over £3bn. If fees applied only to night visits between £3.3m and £14.5m could be generated. Similarly, a universal £2.50 prescription charge would generate over £1bn and a £10 charge would produce over £4bn. However, at present 83% of prescribed items are exempt from charges.

There could be substantial income from hospitals' hotel charges, ranging from £1.25bn (for a £40 charge) to £2.5bn (for an £80 charge). But if current exemptions for prescription charges were applied the likely income would be reduced by half—charges account for only 2.2% of the total NHS expenditure of £46bn.

The paper suggests, however, that the imposition of charges

might affect patients' management of their treatment and that costlier care might have to be provided if a simple condition developed into something more serious. Furthermore, patients who have to pay might have higher expectations of the quality of the service. So the report concludes that, coupled with the complex payment system that would have to be set up, charges would be a barrier to the principle of equitable access.

Only 13% of the population is covered by private health insurance, and the BMA says that if this increased there would have to be a "safety net NHS" for people who could not afford insurance. An alternative would be to ration NHS care to a core of services, with people expected to fund non-core services. But, as the private sector is concerned with profit, insurers would select the healthiest subscribers and exclude high cost care. The main problem would be that access to health care would be based on ability to pay and not on clinical need.

Moving to a social insurance

based system by increasing national insurance contributions and reducing income tax would, the BMA suggests, threaten universal coverage by exposing vulnerable groups and would not address the escalating costs of health care. Furthermore, there was no evidence that this would be any easier to sell to the electorate than raising income tax.

The chairman of the BMA's council, Dr Sandy Macara, said: "We very much prefer direct taxation, which is fair, and it is progressive. If we want services of high quality we must be prepared to pay directly for them as society, as a community." The health secretary, Frank Dobson, has indicated that charges would be considered as part of the government's review of spending. The paper will be sent to the government and could form the basis for debates at next year's annual meeting. □

Options for Funding Health Care is available from the Health Policy and Economic Research Unit, BMA, BMA House, Tavistock Square, London WC1H 9JR.

NHS faces hard choices

John Warden, *London*

The prospect of a winter crisis in the NHS was glossed over by government ministers at last week's Labour party conference. The prime minister, Tony Blair, said that his vision is not just to save the NHS but to make it better: "The money will be there, I promise you that," he said.

And while delegates were disinclined to spoil Labour's election victory celebration, some begged for NHS closures to be reversed. In the conference margins, union leaders refused to rule out industrial action after the chancellor of the exchequer, Gordon Brown, reiterated his call for restraint in public sector pay. The conference took heart, however, when Mr Brown said, "we are now re-nationalising the NHS."

The prime minister told the conference that his theme of modernisation and hard choices

for Britain also applied to the NHS. Barriers between GPs, social services, and hospitals must be broken down, he said. Increasingly, general hospitals would provide routine care, supported by specialist centres of excellence. GPs and nurses would do more of what hospitals used to do, often working on the same site in partnership with chemists, dentists, opticians, and physiotherapists in "health action zones" (5 July, p 7).

Mr Blair said that 10 such zones would be established next April. Their remit would be to experiment with new ideas in the way health care is delivered. Health authorities will bid for special funding to set up the zones. There are also plans for joint control of budgets by health authorities and social services to manage the care of elderly people. "The NHS was a beacon to the world in 1948. I want it to be so again," the prime minister declared.

The health secretary, Frank Dobson, praising NHS staff, said that nobody went into the health service to make a fortune. It was not just pay they wanted, he said. They had to prepare for the challenges of the new century. He

announced an extra £50m (\$80m) next year for professional training, to provide 250 more clinical placements for medical students, 390 more junior doctors, and training placements for 1000 extra nurses. Mr Dobson promised that NHS boards would be drawn from the communities they serve, with people who use local hospitals. But he drew back from a proposal to purge members with private health insurance. (See p 956.) □

Statement

Three days needed to recover from head injuries

Tottenham Hotspur FC has asked us to point out that the footballer Jurgen Klinsmann did see a brain specialist after being injured during a match and that it accordingly refutes completely the assertion to the contrary of Dr Patrick Keating, formerly one of the club's doctors, made in an article published on 16th August, p 387. The club also refutes any suggestion that Dr Keating lost his job because he tried to stop Mr Klinsmann from playing with a head injury. We apologise for the inaccuracies in the article and for any embarrassment caused to the club.

Tony Blair said the NHS should be a beacon to the world

Smoky nightclub discriminated against woman with asthma

Simon Chapman, *Sydney*

The Australian Human Rights and Equal Opportunity Commission has ruled that a woman with asthma was subjected to unfair discrimination when attending a nightclub that allowed smoking.

A day later the tobacco industry suffered yet another blow when the New South Wales government's Workcover Authority issued Sydney's only legal casino with an order to "eliminate the risk of exposure to environmental tobacco smoke in all indoor areas of the casino" after a complaint from the casino's employees union.

Sue Meeuwissen, a double lung transplant recipient, took Sydney's Hilton Hotel to the equal opportunity commission after she had tried to spend an evening in the hotel's nightclub, Juliana's. The commissioner likened her situation to that of a paraplegic person: "For a person who used a wheelchair to be prevented from entering a facility used by the public because of a physical barrier—such as a step or the steepness of a ramp—is not only totally unacceptable but may be unlawful. The situation in

this case, where the barrier relates to the person's capacity to breathe without injury ... is no different." Ms Meeuwissen was awarded \$A2000 (£900; \$1450) and her non-asthmatic companion \$500 for distress caused by the incident.

The judgment has been widely discussed in the media, with detractors arguing that people who go to nightclubs know

what to expect and that if they don't like the smoky atmosphere then they should go elsewhere. A spokesman for the Australian Hotels Association said on national television that Australia's two million asthmatic people should "stay at home."

Health groups, particularly the Asthma Foundation, have welcomed the judgment, seeing it as a furthering the move towards smoke-free indoor public areas. One in 10 Australians are asthmatic, and polls, except those commissioned by the tobacco industry, show large support for smoke-free restaurants, clubs, and to a lesser extent, pubs. □

People with asthma were told to stay away from nightclubs

Inquiry into lung transplant fiasco in Quebec

David Spurgeon, *Quebec*

The Quebec College of Physicians has been placed by the province's health minister, Jean Rochon, in the unenviable position of explaining a mess the minister himself created.

Some months ago Mr Rochon ordered all lung transplant operations to be transferred from Montreal, where they had been carried out successfully for years, to Sainte-Foy, a suburb of Quebec City (1 February, p 325). His decision, unpopular with patients and surgeons alike, was widely interpreted as politically motivated, firstly, because the Sainte-Foy Hospital had no qualified lung

transplant surgeons and, secondly, because the minister's Parti Québécois government is trying to promote Quebec City's role as the future capital of a sovereign state.

The Sainte-Foy Hospital said that it would temporarily employ surgeons from Toronto and France to fill in while its own surgeon was being trained, but these doctors never arrived. Last week Dr Christian Allard, a lung specialist at Complexe Saguenay Hospital at Chicoutimi in northern Quebec on the Saguenay river, blamed the minister for the death of two of his patients who were waiting for transplant operations at the Sainte-Foy Hospital. William Cusano, health spokesman of the opposition Liberal party for the province, called for the resignation of Mr Rochon.

The premier, Lucien Bouchard, rushed to his minister's defence, saying that Dr Allard's first patient died of com-

plications after a transplant operation and that a suitable donor could not be found in time for the second patient.

However, the health minister asked the college of physicians to carry out an inquiry into the patients' deaths. In an interview with the newspaper *La Presse* he said that the inquiry should help to prevent people saying whatever they want about the impact of the transfer of the lung transplant centre.

Dr Augustin Roy, the former president of the college who opposed moving the transplant centre in the first place, said that he did not see how the college could conduct an impartial inquiry under the circumstances. The mayor of Montreal, Pierre Bourque, meanwhile welcomed the news that the centre is now being moved back to Montreal. "It never should have gone from Montreal in the beginning," he said. □

Wages to double for Romanian doctors

Tudor Toma, *Romania*

The salaries of doctors in Romania are to at least double in the next two months, the department of health has announced.

This unprecedented move comes after months of serious criticism of the way doctors are paid and treated by the Romanian government. Currently a consultant earns around £80-90 (\$128-144) a month but a junior doctor earns less than £50. In comparison a senior officer on the government payroll gets up to £400-600 a month plus other benefits. Unqualified workers and cleaners are paid around £40 a month.

Doctors have received low pay since 1945, when the Communists imposed "minimum payments" on doctors and other intellectuals. This was part of a plan to keep all intellectuals totally dependent on the Communist party and its system. Moreover, it was said that as doctors produce nothing, and only spend, they should not be paid much.

After the fall of communism in 1989 most salaries for intellectuals such as lawyers and economists were increased. However, the salaries of doctors were not changed because they were presumed to receive presents and money from patients on top of their salary. Accusations of bribery reached a peak this year when more than 25 doctors were arrested or investigated by police (31 May, p 1573).

"We plan now to bring the doctors' salaries to a decent level," said Mr Teodor Negru, director of budget and finance within the department of health. However, the final levels of pay must still be approved by the department of state finance.

Doctors remain sceptical about the proposal, and most of them are still looking for alternative sources of income within private practice or industry. Anca Popescu, a 29 year old junior doctor in Bucharest, has to work as a part time shop assistant to support herself. "If I get a better position in commerce I'll quit the hospital job without any regrets," she said. □