Video surveillance uncovers parental child abuse

Jacqui Wise, *BMJ*

Evidence of child abuse carried out by parents has been uncovered by secret video cameras hidden in two hospitals, according to a report by Professor David Southall in which he calls for sweeping changes in Britain's approach to child protection.

The report, which is to be published in *Pediatrics* on 3 November, is based on covert video surveillance of 39 children admitted to hospital after recurrent episodes of losing consciousness, going blue, or stopping breathing. There was strong suspicion that the children were in serious danger of life threatening abuse by a parent or step parent.

Parents were secretly filmed and were seen on film attempting to suffocate, kicking, punching, and poisoning their children, who were aged from 2 months to 44 months. The covert surveillance, which was carried out at the Royal Brompton Hospital in London and at North Stafford-

shire Hospital in Stoke on Trent between 1986 and 1994, uncovered deliberate suffocation in 30 of the children. The video evidence led to care orders in 38 of the 39 cases and to 33 criminal prosecutions. After the abuse was detected 23 parents or step parents were identified by a psychiatrist as clearly having a serious personality disorder.

None of the 39 children under surveillance died, but out of a total of 41 siblings, 12 had previously died suddenly and unexpectedly. Eleven of these deaths had been classified as the sudden infant death syndrome, but after the video surveillance, four parents admitted to suffocating eight of these siblings. The death of another sibling supposedly from gastroenteritis was investigated again after video surveillance of her sister showed poisoning and physical abuse. The sibling was found to have died from deliberate salt

poisoning. Other signs of abuse were documented in the medical, social, and police records of a further 15 siblings.

The report says that child abuse carried out by parents with a personality disorder can be extremely difficult to detect. Many parents seemed caring in the presence of professionals, but within seconds of being alone with the child they became cruel and sadistic. The report states: "A proportion of serious child abuse is inflicted by severely disturbed, deceitful but plausible parents. This abuse may be difficult to recognise, life threatening, and associated with extreme degrees of physical and mental harm that are difficult to imagine."

Professor Southall, consultant paediatrician at North Staffordshire Hospital, said: "The United Kingdom has probably one of the best child protection systems in the world, and yet our work, as well as our clinical experience in

child abuse, leads us to believe that the British philosophy, enshrined in the Children Act, of working together with parents will generally fail to protect children from this kind of abuse." His report calls for more assertive methods of investigation and decision making. □

SMITH DAVIS PRESS

Professor David Southall

BMA says that "superhospitals" would be unworkable

Jacqui Wise, *BMJ*

Regional "superhospitals" serving populations of two million would be unworkable and inefficient, concludes a report from the BMA's health policy and economic research unit.

It is widely perceived that the way acute hospital services are organised needs to change because of shortages in specific specialties, greater specialisation within specialties, the changes to working practice caused by the "new deal" and the revised specialist training programme. It has also been argued that the quality of care would be higher in large hospitals.

The report, *Leaner and Fitter*, agrees that fewer but larger sites than at present would be more efficient and would make more cost effective use of expensive equipment but argues that the best solution is a network of larger general hospitals, serving populations of 450 000 each.

The report summarises a modelling exercise that looked at a real (but anonymised) area of England with two million people and 10 hospital trusts spread over 17 sites.

The first option that the report considered was building a new 6000-bed hospital to serve

the entire two million population. This would be newly built on a greenfield site in a central location at a cost of about £860m. Aside from the high cost, the closure of 17 hospitals would be very unpopular with the public. In addition, the report concludes that the massive size would make the hospital very difficult to run, and patients and ambulances would have to travel quite large distances.

A second option would be the redevelopment of an existing site for the superhospital—a slightly cheaper option at £700m but still with the same disadvantages of the first option. A third option would be to have a single regional unit providing mainly high tech services supported by a number of satellite units—for example, "super GP surgeries" and GP hospitals. However, the

report doubts that enough services could be transferred to the community to reduce the size of the central hospital significantly.

The report favours a network of larger hospitals serving populations of around 450 000 each. In the area examined by the report this would mean developing five fully functional district general hospitals from existing sites, with three smaller units offering specialist or stand alone services. This would mean the closure of two trusts and nine hospitals.

Mr James Johnson, chairman of the BMA's Central Consultants and Specialists Committee, said: "The status quo is not an option in the long term. It will be politically difficult, but events sooner or later will make rationalisation of health services inevitable." □

In brief

Placebo arms of AIDS trials in Africa dropped: Researchers in the United States have announced that they will drop some segments of AIDS trials in Africa in which patients received placebo rather than active treatment (27 September p 765). Last month an editorial in the *New England Journal of Medicine* strongly criticised such trials. A spokesman for Johns Hopkins University in Baltimore denied that the move was a response to the criticism.

Senate approves surgeon general: A United States Senate panel has approved the nomination of Dr David Satcher for surgeon general. Dr Satcher's nomination has been controversial because, like President Clinton (who nominated him for the post), he supports "partial birth," late term abortions. Congress wants to ban such abortions except when a woman's life is in danger. Dr Satcher is currently director of the Centers for Disease Control and Prevention.

Rabies eradicated in France: No cases of animal rabies have been reported in France since October 1996, when a fox shot in the Ardennes region near Belgium was found to be infected. The success seems to be due to a vaccination campaign, with helicopters dropping meat containing the vaccine around the countryside.

Gulf war syndrome may be related to unlicensed treatments: Britain's Ministry of Defence has revealed that some of the vaccines used on troops deployed in the Gulf war were medically unlicensed and that the Department of Health had expressed its concerns about them.

More money for HIV treatment in England: An extra £23m (\$37m) to provide combination drug treatment for people with HIV infection and AIDS is to be provided in England next year, bringing the total amount for 1998-9 to more than £228m. A working group has been set up to ensure that this budget is allocated appropriately.

Fetuses cannot feel pain before 26 weeks

Jacqui Wise, *BMJ*

The minimum stage of structural development that is necessary to confer awareness on the developing fetus occurs some time after 26 weeks, according to a report by a working party from the Royal College of Obstetricians and Gynaecologists.

Because of difficulties in estimating gestation the report recommends that doctors should consider giving analgesia or anaesthesia to the fetus when carrying out diagnostic procedures after 24 weeks' gestation. Fetal analgesia and sedation should also be considered when termination of pregnancy is undertaken after this time, according to the working party, which comprised specialists in the anatomy and physiology of developing nerves, fetal and child health, anaesthesia, the law, and bioethics.

The report concludes that until nerve connections are established between the cortex and the thalamus in the brain then sensations of pain cannot be experienced by the fetus. Noxious stimuli can initiate

Nerves between the cortex and thalamus develop after 26 weeks

stress responses, but these neither imply nor preclude suffering, pain, or awareness. It is not until 26 weeks' gestation that there starts to be structural integration of peripheral nerves, spinal cord, brain stem, thalamus, and cerebral cortex.

The report states that no major "surgery" on fetuses is being performed in Britain and most diagnostic tests do not involve direct contact with the fetus. But when direct contact is made then analgesics and anaesthetic agents should be considered. The report points out that the effects of such agents on the subsequent development of the

fetus are not known and more research is needed into this area.

Dr Anne McLaren, chairwoman of the working party, said: "Fetal awareness of pain is a very emotive topic, of particular concern to pregnant women, but we have tried to approach it without preconceptions, to examine the scientific evidence dispassionately, and to identify areas where further research is urgently needed." □

Copies of the report are available from the Royal College of Obstetricians and Gynaecologists' bookshop (tel: 0171 772 6275), price £6 plus postage.

No fault compensation for medical accidents under consideration

Clare Dyer, *legal correspondent, BMJ*

The Lord Chancellor, Lord Irvine, is considering reviewing the feasibility of a "no fault" compensation scheme for cases in which medical treatment goes wrong.

Such a scheme, which operates in New Zealand and Sweden, would pay compensation for brain damaged babies and other victims of medical accidents, without the need to mount costly legal action to prove that the doctor was negligent. The move has been recommended by Sir Peter Middleton, former permanent secretary to the Treasury, whose six month review of civil justice and legal aid was published last week. The Lord Chancellor asked him to look at proposals that were in the pipeline for reform-

ing legal aid and the civil justice system when Labour took office, before deciding how far they should be implemented.

Sir Peter says in his review: "The bulk of the resources deployed to deal with medical negligence are from the public sector—the health and legal aid budgets. It makes very little sense to have an increasing amount of time and money from the health budget extracted in legal fees rather than patient care, and to engage in a set of arrangements where legal professionals can earn more from public funds than health professionals."

A spokesman for Lord Irvine said: "The Lord Chancellor views the recommendation with interest and will wish to consider

the benefit of such a review, with particular regard to clinical negligence." The idea was looked at nearly 20 years ago by a royal commission—the Pearson Commission—which reported in 1978. It decided against recommending a no fault scheme for medical accidents because of difficulties in defining the scope and financing a scheme and because it saw no reason why doctors should be put in a special position. But in the past 20 years both claims and costs have risen dramatically, putting NHS budgets under growing pressure. Sir Peter says: "The subject matter is inherently difficult to deal with via the legal process. It is difficult—one might say impossible—to draw a clear line between misfortune and negligence. Even if one could, it is difficult to accept that those just one side of the line should receive large sums in compensation and those the other side should receive nothing." □

Organophosphates do cause long term damage

Clare Dyer, legal correspondent, *BMJ*

A High Court judge has made the first finding in a British court that exposure to organophosphates causes long term damage.

Mrs Justice Smith found that a Peterborough farm worker, John Hill, had experienced persistent neuropsychological and neurobehavioural effects from two exposures to the insecticide Actellic-D, whose active constituent is pirimiphos-methyl.

The judge also accepted the view of Peter Behan, professor of neurology at Glasgow University, that the exposures had caused Mr Hill to develop a condition similar to the chronic fatigue syndrome. But she dismissed claims by another of Mr Hill's experts, Goran Jamal, also of Glasgow University, that organophosphates cause long term peripheral neuropathy and abnormalities of the autonomic system.

Mr Hill's employer, the company William Tomkins, had admitted negligence but argued that exposure could not cause long term effects. Mrs Justice Smith said of Professor Behan's evidence: "Had [he] expressed himself with greater moderation and objectivity and had he not sought to misrepresent the effects of his research, my task would have been a great deal simpler." Lawyers for William Tomkins had accused Professor Behan of "cooking" the results in a research study that formed part of the evidence (2 August p 271). An investigation by the university cleared him.

The judge expressed disquiet about the role of expert witnesses in the case. She said that over nine months Mr Hill had been examined by 11 medicolegal experts, a process which had created anxiety and led him to

believe that he was more ill than he was. She added: "It is remarkable to observe the extent to which some of the doctors have elicited a history which has enabled them to conclude that the plaintiff is suffering from a condition which is relevant to their own special research interest," she remarked.

She thought that Professor Behan, Dr Jamal, and another expert "to a large extent heard what they wished to hear." Dr Jamal twice carried out sets of tests which showed peripheral neuropathy. The same tests carried out by the defendant's experts showed no such signs. Dr Jamal repeated his studies, this time with closely similar results to those of the defendant's experts. The judge commented: "I am driven to the conclusion that, for some reason, Dr Jamal reported test results which appeared to demonstrate phenomena and abnormalities which I am satisfied were not present." The judge said that this might have been due to a fault of technique or to lack of objectivity.

Mrs Justice Smith accepted that Mr Hill had genuine symptoms of tiredness, muscular weakness, loss of concentration, irritability, and mood swings. But she said that before long his neurobehavioural symptoms had become overlaid by a psychological reaction to the physical illness and loss of employment. While being subjected to so many medicolegal examinations, he became convinced that his health was permanently ruined and took to a wheelchair. Once the litigation was over, she thought the residual effects of exposure would be "of a low order."

Lawyers for the plaintiff and the defendant are now expected to reach an out of court settlement on damages. Courts in Australia and Hong Kong have awarded damages for long term effects of organophosphate poisoning this year; in two cases Dr Jamal was an expert witness. Hundreds of claims by Gulf war veterans and by farm workers alleging damage by sheep dip and pesticides are pending in Britain. □

Complementary medicine should be integrated into the NHS

Zosia Kmietowicz, *London*

A report on the future role of complementary and alternative medicines and how therapies such as homoeopathy, acupuncture, and osteopathy can be more fully integrated into the NHS has been widely welcomed.

The report is the culmination of 18 months' work by four working groups set up in February last year at the request of the Prince of Wales. The document, which is part of the Prince's Initiative on Integrated Medicine, is designed to stimulate debate on the possible role of complementary medicines within the health-care system before the issues are explored further at a conference next summer. It contains 28 specific proposals and highlights research, professional regulation, education and training, and effective delivery of integrated health care as priority areas.

Though he welcomes the initiative, Edzard Ernst, professor of complementary medicine at the University of Exeter, is con-

cerned that the enthusiasm for alternative medicine may lead to its acceptance within mainstream medicine without evidence from trials that it is effective. The report cites evidence that complementary and alternative medicine is effective, but this is plainly "over-optimistic," said Professor Ernst. "The evidence is not there yet for many therapies. For example, according to a Cochrane review, the majority of trials do not support acupuncture for asthma as an effective treatment, yet this is the impression given in the report," he said. "I do support this report and am in favour of complementary medicine, but integration should be after evaluation and not the other way round. If trials come out in favour of complementary and alternative medicine then integration should proceed in an organised way."

Stephen Holgate, clinical professor in immunopharmacology at Southampton Univer-

Prince Charles is a great advocate of complementary medicine

sity and a member of the steering committee that produced the report, agreed: "If we are going to bring complementary and alternative medicine into mainstream health care then we have got to have the evidence, otherwise the health service is not going to invest in it. We have got to show that it works, how it works, and for which indications it works best," said Professor Holgate.

Several organisations, such

as the Wellcome Trust and the Medical Research Council, have already shown an interest in carrying out some work in the area. Tessa Jowell, minister for public health, welcomed the report and said that she would "explore its recommendations." □

Integrated Healthcare: A Way Forward for the Next Five Years? is available from the Foundation for Integrated Medicine, 83 Kingsway, London WC2B 6SD, price £10.

Regulation has not reduced food poisoning in Britain

Susan Mayor, *London*

Cases of bacterial food poisoning in the United Kingdom have increased fivefold over the past 15 years despite attempts to improve regulation, according to a report published this week by the Parliamentary Office of Science and Technology.

The report states that notifications for bacterial food poisoning in England and Wales increased from 14 000 cases in 1982 to 83 000 in 1996; figures for Scotland rose from 2700 to over 10 000. Dr Peter Border, parliamentary adviser with the Parliamentary Office of Science and Technology, the body that provides parliament with independent analyses of scientific issues, said: "The overall picture is of a large risk in food poisoning notifications; [food poisoning] now affects almost 100 000 people each year."

Escherichia coli O157 was virtually unknown before the 1980s, but overall rates for the United Kingdom have since risen to over 1100 cases in 1996 (see figure). Although far less common than *Helicobacter pylori* or salmonella, it causes more serious illness. Scotland shows the highest rate, at 9.5 cases per 100 000 population in 1996, compared with 1.3 cases per 100 000 population in England and Wales.

The 1996 outbreak of *E coli*

O157 in central Scotland affected 496 people, 20 of whom died—the largest number of deaths associated with any such outbreak worldwide. An inquiry into the outbreak, led by Hugh Pennington, professor of microbiology at the University of Aberdeen, called for wide ranging measures, from higher standards in abattoirs to a licensing system for butchers' shops, to ensure hygiene practices are maintained (19 April, p 1147).

The report says that the increase in food poisoning has occurred despite increasing regulation of food production and the use of new technology in the food chain. It finds no simple, single answer to this anomaly but suggests that changes in agricultural sources are likely to be one of the most important factors. "Regulatory changes designed to improve hygiene in meat production may have backfired," warned Dr Border. For example, changes in hygiene regulations resulting from European initiatives have reduced the number of abattoirs in the United Kingdom by 75% over the past 20 years, increasing journey distances and times for most animals. This increases the soiling of animals, which has been shown to increase dramatically the bacterial content of resulting meat. "The

net effect on bacterial quality of the meat leaving the abattoir may have been the opposite of that intended," he pointed out.

The report says that simple measures, such as ensuring that animals are clean when delivered to abattoirs and installing thermometers in fridges, may help. "But there is a fundamental need for better coordination of measures affecting the quality of food across all stages in its production, from farming through to the consumer," said Dr Border.

The Food Standards Agency, which should come into action by 1999, offers the most likely way of achieving this, by transferring prime responsibility for food policy from the Ministry of Agriculture, Fisheries, and Food to the Department of Health and removing the apparent conflict

between public health and business interests (17 May, p 1433).

Professor Philip James, director of the Rowett Institute in Aberdeen, who proposed the agency, said: "The data suggest that we are looking at a long term problem which will get worse unless we take action." He suggested that this will require a completely new look at the food chain. "Until now, everyone has assumed that the consumer was to blame. But it is becoming clear that changes in animal husbandry may well be implicated and that widespread action is required," he concluded. □

Safer Eating: Microbiological Food Poisoning and its Prevention is available from the Parliamentary Office of Science and Technology, 7 Millbank, London SW1P 3JA, price £14.

Notifications of *E coli* O157 have risen sharply in the UK

Legal aid withdrawn from negligence cases

Clare Dyer, *legal correspondent, BMJ*

The Lord Chancellor, Lord Irvine, has announced a wide ranging shake up of legal aid and civil justice, which will have far reaching repercussions for medical negligence litigation in England and Wales.

Legal aid is to be withdrawn from all money and damages claims, including medical negligence. The government expects lawyers to fill the gap by a big expansion of "no win, no fee" deals (in which the loser pays the

winner's costs). But the Bar and the Law Society warn that the high costs that have to be paid in advance in such cases may prevent poorer clients from bringing claims. They point out that it costs £2000-£5000 (\$3000-\$8000) to investigate the strength of a medical negligence claim before a view can be taken on its chances of success. And insurance against the cost of losing will be beyond the pockets of many.

From next April lawyers will be able to take any money or damages claims on a no win, no fee basis. At present such deals are limited to cases relating to personal injury, insolvency, and European human rights. A few medical negligence cases are already going ahead under no win, no fee agreements, but the

insurance is prohibitively expensive for most people—up to £15 000 for £100 000 of costs. By contrast, a road accident case can be insured for a flat fee of £95.68 and other types of personal injury for £161.20. The differences reflect the low rate of success and high cost of medical negligence cases—only 17% succeed, compared with 85-90% for other personal injury cases, according to figures from the Legal Aid Board.

A new insurance product launched last week, Medical Accident Protect, will cover £100 000 of costs for premiums ranging from £4000 to £7500. Litigants will be able to pay the premium on a monthly basis. Insurers will underwrite only those cases handled by solicitors who are mem-

bers of the Law Society's medical negligence panel, said James Innes, chairman of Abbey Legal Protection, which is offering the new insurance. The result should be to limit cases only to solicitors of proved competence, which could mean a substantial improvement in the rate of success. It should also mean that fewer "no hope" cases are brought.

The Lord Chancellor is considering whether legal aid might pay the premium and investigation costs for poor litigants, particularly in birth damage cases. He has also suggested that solicitors might finance this outlay themselves. Mr Innes said: "Solicitors might be willing to pay the premium if they could claim it back as part of the costs when the case was won." □

Rotavirus vaccine is effective in developing countries

Deborah Josefson, *San Francisco*

An oral vaccine that has the potential to prevent most life threatening rotavirus infections has been shown to be safe and effective in both developing and developed countries. Concern has been raised, however, that it might be prohibitively expensive for the nations that need it most.

Infectious diarrhoea is a leading cause of paediatric morbidity and mortality worldwide. There are an estimated 130 million cases of diarrhoea caused by rotavirus each year—18 million of which are classed as severe—resulting in 873 000 deaths annually.

Several studies have shown that a live attenuated vaccine incorporating the four rotavirus serotypes that cause most of the illness in humans is 80% effective in developed countries. The vaccine has proved disappointing, however, in developing countries such as Brazil and Peru, where it has proved to be only 15-20% effective, although it reduced severe episodes by about 40%.

Last week a trial carried out in Finland confirmed that the vaccine is effective in developed countries (*Lancet* 1997;350:1205-9), and a trial carried out in Venezuela is the first to show the

vaccine's promise in a developing country (*New England Journal of Medicine* 1997;337:1181-7). This study, based at a paediatric hospital serving a poor, urban population, included 2207 full term, healthy infants who were randomised to receive either the vaccine or placebo at age 2, 3, and 4 months. The vaccine was found to have an overall effectiveness of 48%, but severe diarrhoea was reduced by 88%. Moreover, dehydration, the most life threatening complication, was reduced by 75%, and hospital admissions fell by 70% in the vaccinated group. The vaccine was well tolerated; mild fever, which occurred in 15% of infants within days of ingesting the vaccine, was the most common side effect. Vaccine strains were also shed in the faeces, raising the possibility of an added benefit of herd immunity.

Dr Albert Kapikian, who led the Venezuelan study, said that the goal of the vaccine was to reduce, rather than eliminate, the severity of the disease: "We would not anticipate that a live, attenuated vaccine would do better than a wild-type virus. The concept of eliminating the virus, like smallpox, will not occur with rotavirus because reinfections are very common.

EM UNIVERSITY OF SOUTHAMPTON/SL

Rotavirus causes 130 million cases of diarrhoea a year

The purpose of the vaccine is to prevent more severe illness."

An effective rotavirus vaccine would be particularly useful in developing countries, where the virus circulates all year round rather than seasonally. The higher proportion of malnourished and immunocompromised individuals and poorer access to clean water and health care help to create a ripe environment for the spread of infectious disease.

The vaccine, manufactured by Wyeth-Ayerst, has not yet been

priced but the cost is estimated to be around £19 (\$30) a dose, or £56 for the full course. In an accompanying editorial in the *New England Journal of Medicine* (p 1228-9) Dr Gerald Keusch of Tufts New England Medical Center and Dr Richard Cash of the Harvard School of Public Health argue that the vaccine would be too expensive for developing nations and that they might be better off treating the severe symptoms with cheap and effective oral rehydration solutions. □

Combined blood and urine testing is more sensitive for HIV

Kamran Abbasi, *BMJ*

Testing samples of both blood and urine can increase the sensitivity of detection of HIV-1 antibodies compared with serum or urine testing alone.

Howard Urnovitz, chief science officer, and his team of researchers from the Calypte Biomedical Corporation, say that this finding may open new avenues in the development of an AIDS vaccine (*Nature Medicine* 1997;3:1258).

The team tested blood and urine samples from 11 344 patients and found that in 1181 individuals 1156 samples were positive for HIV-1 antibodies

by both methods, 15 samples were positive by serum alone, and 10 samples were positive by urine only. Testing serum samples alone showed a 99.15% sensitivity, whereas urine sample testing showed a 98.73% sensitivity. The combination of blood and urine testing resulted in 100% sensitivity. All positive tests were confirmed by the western blot technique.

Dr Urnovitz said: "The detection of HIV-1 discordant samples is not that surprising. As early as 1990, studies have shown that individuals can be antibody positive in one body fluid but negative

in another. Every individual's immune system responds differently to viral infections. This study suggests that a small, but significant, percentage of individuals appears to confine the HIV-1 infection to a limited number of tissues and organs, a process called compartmentalisation."

Another study in the same issue of *Nature Medicine* supports the concept of compartmentalisation and suggests that mucosal IgA plays a protective role in seronegative individuals who have been exposed to HIV (p 1250-7). Mario Clerici of the department of immunology at the University of Milan and his team examined blood, urine, and vaginal samples from 16 heterosexual HIV-1 positive men and women and their partners (exposed to HIV-1 but seronegative). They found HIV-1 specific

IgG and IgA antibodies in the blood, urine, and vaginal samples of the seropositive individuals, whereas their seronegative partners had no IgG antibodies but strong IgA responses in their urine and vaginal samples.

Although this may simply reflect exposure to HIV-1, the suggestion is that a vigorous mucosal immune response may prevent individuals exposed to HIV-1 from seroconverting. Professor Luc Montagnier, who discovered HIV-1 and is a member of Calypte's scientific advisory board, said: "The possibility of identifying naturally immune people gives us more directions to pursue for a successful treatment against the AIDS virus. We need to focus our resources on how to translate these findings of natural immunity into safe and effective vaccines." □

Norwegian doctors in row over jobs for foreign doctors

Sandra Goldbeck-Wood, *BMJ*

Norwegian doctors have broken their tradition of cooperating with the government to ensure healthcare provision for Norway's remotest regions, because of a controversial ruling that excludes Norwegian doctors from some specialist posts.

At the annual conference of the Norwegian Medical Association in Bergen last week, doctors unanimously agreed that if the government fails to respect doctors' employment interests, the association will withdraw cooperation from the agreement that regulates the number of specialists allowed to practise in each area. If the threat is realised,

regions such as the Arctic areas of northern Norway could face a serious shortage of GPs and hospital specialists.

The "doctor distribution agreement" was created in 1989 to address recruitment difficulties in Norway's most remote regions, where the areas covered are huge and geographical conditions are hostile. The agreement limits the number of specialist positions that can be created by local authorities in each area of Norway, according to a formula designed to achieve even cover across the country. This prevents local authorities from creating a disproportionate

number of jobs in "desirable" areas, such as Oslo and southern Norway.

The dispute has arisen out of a unilateral decision taken two weeks ago by Norway's former prime minister, Dr Gudmund Hernes, to create 10 new specialist posts at Oslo's main hospital for cancer that will be open only to applications from foreign specialists. Dr Hans Peter Aarseth, president of the Norwegian Medical Association, said the situation is intolerable: "We recognise the need to recruit foreign specialists to fill gaps where Norwegian specialists are not available and are positive towards this. But to create jobs from which Norwegian doctors are excluded sets an unacceptable precedent."

According to Dr Hernes, the move was intended to fill a gap without causing a "brain drain"

on specialists already practising in the remote regions. The new Norwegian government has only a small majority and is not expected to make any changes to the plan.

This decision could hasten the worst crisis that Norwegian primary health care has seen since the 1970s, according to Professor Steinar Westin, a GP from Trondheim, in the north of the country. He said: "The doctor distribution agreement was already rather ineffective, and any withdrawal from it could make things much worse. For the past seven years or more it has been difficult to recruit younger GPs."

He added, "Most regional GPs are approaching the age of 50, when they become exempt from on call duties, and when they retire there will be no one to take over." □

Dr Jack Kevorkian, the well known advocate of assisted suicide, has announced that he will offer organs harvested from his suicide patients to people waiting for transplants. The first organs, most likely lungs and a heart, will be donated on a first come, first served basis within the next few months, he said. "Here's a case where we can end the suffering of a patient and get organs back to save lives," he said. Cardinal Adam Maida, Archbishop of Detroit, where Dr Kevorkian lives, has denounced the plan.

French doctors apologise for wartime antisemitism

Alexander Dorozynski, *Paris*

French doctors have followed the example of the French government, the Catholic church, and French police in apologising to Jews for the attitude of part of their profession during the German occupation.

At a general assembly of regional representatives, Dr Bernard Glorion, president of the Conseil National de l'Ordre des Médecins, the French medical association, said that doctors—some under duress, others by ideology—participated in the discriminatory Vichy government's policies to "contribute to the vigour of the [French] race" and to ensure that Jewish people did not represent more than 2% of doctors practising in any region.

Dr Glorion's announcement coincided with the start of the trial of Maurice Papon, a former official under the Vichy government charged with "crimes against humanity" for helping to round up Jews for deportation. The trial, expected to last two to three months, has triggered an agonising reappraisal of the role of many French people during the German occupation.

However, many doctors objected to the collective guilt

suggested by Dr Glorion's apology, pointing out that some doctors helped Jewish patients to escape prison and deportation. Others stated that the association was simply following the "politically correct" trend started by President Jacques Chirac when he acknowledged the guilt of the French state during the German occupation.

"This parade of repentances, so belated, is becoming a mockery," said Dr Françoise Spinner, a physician and historian. The Committee of Doctors with Foreign Diplomas approved of the apology but objected to the "disdain and silence" of the medical association in the face of discrimination that "foreign doctors" are subjected to.

The medical association has also been criticised for denying researchers access to the association's wartime archives. Some of the records were reported to have been burned accidentally and others to have disappeared when the association moved in 1995. Dr Bernard Kouchner, secretary of state for health, has asked that the association's records be made available for historical studies, and Dr Glorion has agreed to comply. □