GMC accused of prejudicing doctors' defence

Clare Dyer, legal correspondent, BMJ

The General Medical Council (GMC) was accused last week of prejudicing the defence of three doctors accused of serious professional misconduct over heart surgery on babies and children.

Two consultant surgeons, James Wisheart and Janardan Dhasmana, are accused of carrying out operations beyond their technical competence when they were aware of concerns about high mortality, and the former executive of the United Bristol Healthcare Trust, John Roylance, is accused of allowing the operations to go ahead (18 October, p 967). Mr Wisheart, who was also the trust's medical director and who has since retired, is also accused of misleading parents about the risks of death or brain damage.

The charges relate to operations carried out between 1988 and 1995 at the Bristol Royal Infirmary on 53 babies and young children, of whom 29 died and four were left brain damaged. Concern centred particularly on arterial switch operations for transposition of the great arteries. The GMC hearing is to be followed by a government inquiry.

It emerged last week that the GMC sent "chapter XV letters" to three other Bristol consultants—two cardiologists and an anaesthetist, who were not named. They were told that, while the council had no current intention to take proceedings against them, there might be grounds for thinking that their conduct was not up to the required standard, and they were invited to comment on an attached schedule.

The recipients of the letters, after taking legal advice, had refused to give evidence. For Mr Dhasmana, Nicola Davies QC said: "The defence case is not simply hampered, it is prejudiced by reason of the actions of

this council." Duncan Matheson, Mr Wisheart's QC, said: "It puts us in an appallingly difficult position, that the cooperation which we hoped we were getting dried up in midstream."

Applying for disclosure of the letters, Miss Davies said that the defence was "having to fight blind" as to their content, though aware of the recipients' identities. The committee agreed to disclose the letters on condition that they were kept confidential.

The hearing, which is scheduled to end in late January, was adjourned last Friday until 24 November, after three weeks of evidence. Witnesses so far include Stephen Bolsin, the consultant anaesthetist who first raised concerns over the mortality rates; Professor Gianni Angelini, who came to Bristol in 1992 to set up an academic department of cardiac surgery; and Peter Doyle, senior medical officer at the Department of Health to whom Dr Bolsin voiced his concerns.

Dismissive reaction

Dr Bolsin, who now works as a consultant in Australia, told the hearing: "We were not talking about the length of a scar or two extra days in hospital. We were talking about babies dying, and I wanted to see the end of it as soon as possible." He said that he wrote to Dr Roylance and the district health authority (the trust's predecessor) in 1990, but Dr Roylance's reaction was "fairly dismissive." Dr Bolsin said that Mr Wisheart had sent for him and said that he was angry that the letter had been sent outside the unit, and that was not the way to carry on if he wanted to continue his career at Bristol.

He told the hearing of a meeting held in January 1995 to decide whether a switch opera-

Parents showed their support for James Wisheart outside the GMC

tion should go ahead on 18 month old Joshua Loveday. He urged colleagues to postpone the operation until the arrival of a new paediatric cardiac surgeon. But the operation went ahead, and the child died.

Ash Pawade, the new surgeon, who took up his appointment in May 1995, said that he had previously worked in Melbourne, Australia, where he had performed 28 switch operations with no deaths. He had carried out some 600 heart operations at Bristol, with mortality of 3-3.5%.

He said that the contrast between the practice in Australia and Britain highlighted the weakness of paediatric cardiac surgery in Britain. In Britain a senior registrar did not perform operations independently, but when he became a consultant he was expected to do so immediately. In Melbourne, he had had a more experienced consultant on hand during operations in the initial stages after becoming a consultant.

Professor Angelini said that he had tried to raise the alarm over "unacceptable" death rates among babies undergoing switch operations for more than

a year before Joshua Loveday's operation. He had urged Dr Roylance not to allow the operation to go ahead, and suggested to the doctor who had referred him that he should send him to a unit in Birmingham with better survival rates.

Dr Doyle said that he had spoken to Dr Roylance before Joshua Loveday's operation. "I pointed out that if this was not an emergency and the child was not in imminent danger and there was any question about the risk, it would not be in the patient's best interests to proceed, nor those of the trust." He said that Dr Roylance had replied "something to the effect that he would have to be guided by his medical director."

Robin Martin, the cardiologist who referred Joshua Loveday for surgery, told the hearing that at the clinical meeting when the decision was taken to go ahead with the operation, everyone had agreed with that course of action, except Dr Bolsin. The meeting agreed that Mr Dhasmana's figures for non-neonatal switch operations were good and that the operation should go ahead. □

In brief

Polish anaesthetists on hunger strike: Anaesthetists in many Polish hospitals have been on hunger strike over pay and conditions. Many anaesthetists earn only £130 (\$200) a month.

Japan urged to lift ban on oral contraceptives: A panel that advises the Japanese ministry of health and welfare has recommended that women should be allowed to use low dose contraceptives. This could pave the way for the removal of Japan's ban on oral contraceptives.

Reporting scheme for HIV drugs launched: The Medical Research Council, the Medicines Control Agency, and the Committee on Safety of Medicines have launched a reporting scheme for suspected serious adverse reactions to medicines used in treating people infected with HIV. The scheme complements the "yellow card" scheme (for reporting adverse drug reactions).

New president of World Medical Association: Dr Azrul Azwar of the Indonesian Medical Association is to be installed as president of the World Medical Association at next week's general assembly in Hamburg. Dr Delon Human from South Africa will become the secretary general of the association in January.

Use of antibiotics in animals should be curtailed: A World Health Organisation meeting of 70 health experts in Berlin agreed that excessive use of antimicrobials, especially those used as growth promoters in animals destined for human consumption, is a growing risk to human health and should be reduced.

NHS medicines should face cost test: All new drugs should be subject to a cost effectiveness assessment before becoming available on the NHS, Professor Alan Maynard, a health economist, told a conference last week. He also wants the government to set up a system to establish whether expensive new equipment is cost effective.

Court confirms right to palliative treatment for mental distress

Clare Dyer, legal correspondent, *BMJ*

The right of doctors to give terminally ill patients palliative treatment to relieve mental distress as well as physical pain and suffering was confirmed in a test case settled in the High Court in London last week.

Annie Lindsell, who has motor neurone disease, sought a court declaration that her GP, Dr Simon Holmes, could administer large enough doses of diamorphine to render her unconscious when her ability to swallow food became affected. Having seen friends die of the disease, she did not want to go through the final stages choking on her food and unable to speak. She has already made an advance directive refusing feeding by tube.

The attorney general briefed a QC, Presley Baxendale, for the ground breaking case, because of the criminal law implications. Doctors who administer medication with the intent to kill a patient could face a murder charge. Ms Lindsell withdrew her application for a court ruling after the lawyers agreed that the course of action she sought was acceptable medical practice. Her lawyers produced affidavits from experienced GPs and experts in palliative care stating that the treatment programme proposed by Dr Holmes was in line with good medical practice.

The case first came to court a fortnight ago but was adjourned for further expert reports. The

day before it reached court, Dr Holmes was warned by his counsel—provided for him by the Medical Protection Society—that he could face a possible murder charge if he carried out the treatment proposed, or conspiracy to murder for even agreeing to it. For technical reasons, he was the defendant in the case, although he supported the treatment, and the Official Solicitor sent him a letter warning that he could face a bill for legal costs.

He decided he would have to withdraw from the case but changed his mind after late night conversations with Ms Lindsell, her partner, and his own partner. "Having been pushed into a corner and tempted to give up completely, I thought, 'no, I can't do this,'" he told the *BMJ*. "I've been through a very unpleasant process with this whole business. But it has been quite a strengthening process for me."

The case revolved around the doctrine of double effect, under which doctors may give medication to relieve pain and suffering, even if the result is to shorten the patient's life, so long as this is not the intention. Dr Holmes said: "The idea wasn't that I was going to anaesthetise her to death. I don't believe in euthanasia. But I do believe in forthright and unhesitating relief of distress and pain, with no half measures."

"What I was really saying to the court was that I was going to treat Annie at the time when she develops symptoms which prevent her from eating and drinking. This would allow her to sleep; therefore there would be no eating or drinking. The decline into death is quite predictable." (See p 1242.) □

Annie Lindsell is satisfied with her proposed treatment

UK screening programmes to be overhauled

Linda Beecham, *BMJ*

The UK health secretary has ordered a reform of breast and cervical cancer screening programmes following the publication of a report into the failure of the breast screening service in Exeter.

An audit of 1920 mammograms commissioned by the

Royal Devon and Exeter NHS Trust found that 229 women should have been called for further assessment. The audit found evidence that two radiologists had failed to provide care to a standard expected of consultants involved in breast imaging. Frank Dobson asked the chief medical officer to investigate, and his report includes a review of national arrangements for quality assurance in breast cancer screening.

All trusts with breast cancer screening units are being told to review their arrangements. They must report the outcome of

their reviews to the regional director of public health and the national coordinator of the breast cancer screening programme by 31 January 1998. By the end of February all health authorities, trusts, and regional offices will be expected to have an action programme in place to ensure that all screening programmes meet national standards. By 1 April responsibility for quality assurance will be removed from purchasers and restored to NHS regional offices; they will close units which fail to meet national standards. □

Alcohol, not drugs, causes most problems at nightclubs

Jacqui Wise, *BMJ*

Despite the huge publicity surrounding ecstasy and other "designer drugs," alcohol is still the major cause of admissions to accident and emergency departments among nightclubbers.

Dr Chris Luke, consultant in accident and emergency medicine at the Royal Liverpool University Hospital, said that the increase in drug misuse among clubbers has not stopped people consuming alcohol. He told the club health conference, held at Cream nightclub in Liverpool last week: "We are not seeing alcohol displaced—rather there is an overlap with drugs and an increasing tendency for people to take drug cocktails."

He told the conference—

attended by delegates from the police, local authorities, and drug agencies—that accident and emergency departments are having to cope with increasing numbers of clubbers. He estimated that between 700 and 1500 clubbers were admitted to his department every year. A study of 400 patients showed that the average length of stay was two hours, but 40% needed an ambulance and a third needed expensive x ray examinations, with a similar number needing follow up in a specialist clinic. "The tab for social self indulgence is picked up by NHS staff," he said.

He spent some time in Cream nightclub, one of the biggest in the country, to look at the prob-

lems first hand. "Drugs are an important problem, but alcohol, glass, and violence are the main problems," he said. He said drugs were ubiquitous on the club scene, but a kneejerk simplistic response was inappropriate. He said the Dance till Dawn Safely initiative by the London Drug Policy Forum was the way to

reduce the burden on the NHS. The initiative ensures that clubs have water freely available, "chill out" rooms, toughened glass, and trained first aiders. "I think the message about hydration and cooling down is getting through, and we are seeing less problems with overheating due to ecstasy use," he said. □

Clubbers face danger from alcohol, glass, and violence

Most people should pay for NHS drugs

Linda Beecham, *BMJ*

NHS prescriptions should be abolished, except for people who cannot afford them or who are chronically ill.

The proposal comes from the right wing think tank, the Institute of Economic Affairs, which argues that the present system, in which 83% of prescriptions are free and the rest cost £5.75 (\$9.20) an item, is pointless and wasteful. In *Should Pharmaceutical Prices be Regulated?* the institute's health and welfare unit points out that each member of the population receives 9.5 prescriptions a year, covering drugs to the value of £87. Most people could easily afford such a sum, and it would be more efficient to allow them to pay.

The book examines the different methods by which governments try to control drug prices and asks whether it is desirable that they should do so. The unit's director, David Green, says that most governments regulate drug prices because the drugs are provided through the state health system and they are usually the only purchaser.

Several contributors criticise the method used in Britain to control drugs. Under an agreement between the Department of Health and the Association of the British Pharmaceutical Industry, which is due to be renegotiated in 1998, the pharmaceutical price regulation scheme controls the level of profits of firms that supply the NHS. The institute says that the scheme distorts the industry. By standing in the way of price flexibility it prevents suppliers from trying out different pricing strategies, and, by fixing the amounts allowed for research and development, it may constrict research if the amounts are too little or encourage waste if they are too large.

The pharmaceutical price regulation scheme, prescription charges, and exclusion lists are used to save money for a state run healthcare system. But the book asks whether governments should limit pharmaceutical expenditure when many drug treatments were known to be cost effective. If the right drug treatments prevent or reduce the need for hospital treatment it may not be in the government's economic interests to restrict drugs. □

Should Pharmaceutical Prices be Regulated? is available from the Institute of Economic Affairs, London SW1P 3LB, price £12.

Shift to CFC-free inhalers may require change in doses

Adam Legge, *Newcastle*

General practices and hospital asthma clinics will face a significant rise in workload when current metered dose inhalers are switched to versions that are free of chlorofluorocarbons (CFCs), doctors in Britain have been warned. Many patients will need their treatment doses adjusted when the compulsory change happens, which is likely to start next year.

Medical, nursing, and pharmacy representatives met recently in London to discuss the switch. Doreen Hepburn, a group manager for the Medicines Control Agency, told them: "Reformulating the [inhaled] corticosteroids has been a particular problem, and we are starting to see differences in dosing."

The first CFC-free beclomethasone inhaler is likely to become available early next year, and data from that product suggest that it behaves differently from current metered dose inhalers. Substituting the CFCs with a hydrofluoroalkane propellant dispenses the drug in much finer particles, which penetrate deeper into the lung. Data supplied to the Medicines Con-

trol Agency suggest that this gives it equivalent efficacy for half the dose.

At the moment only one CFC-free inhaler is available—Aeromir, which contains salbutamol. That product does not show any pharmacokinetic difference from existing products.

European Union legislation on phasing out the existing medically exempted CFCs is close to completion. Draft legislation states that as soon as two CFC-free beclomethasone products, plus one other inhaled steroid, are licensed the existing metered dose inhalers should be withdrawn. Similar action is recommended when two salbutamol products are available.

Martyn Partridge, consultant physician at Whipps Cross Hospital, London, and chief medical adviser to the National Asthma Campaign, said: "The sheer number of patients involved is going to be bigger than [were involved in] the reformulation of digoxin or the switch over to human insulin in diabetes. It's important to emphasise that this is not going to be an optional change." □

South Africa's controversial health bills

Pat Sidley, *Cape Town*

South Africa's parliament has passed three controversial health bills, each of which has been the subject of bitter dispute and may well have long term legal repercussions.

One bill ensures that all graduating doctors will have to complete a year's "community service" in an area which has too few doctors.

The government, dominated by the African National Congress, has had to cope with a mass exodus of doctors. For example, Northern Province, a largely rural, poor area with 5.1 million people, has only 400 doctors.

The minister of health, Dr Nkosazana Dlamini-Zuma, has tried to plug some of the gaps with Cuban doctors—a move that also caused an outcry from various interest groups. Several groups of interns have sought legal advice and are preparing for a legal challenge to the move for community service.

In addition, several thousand dispensing doctors, as well as

Dr Nkosazana Dlamini-Zuma's actions have caused an outcry

many multinational pharmaceutical companies, are threatening action after parliament passed a bill introducing strict controls over dispensing doctors as well as ensuring that drugs were available at lower prices. The bill allows parallel imports of drugs if local supplies of brand name drugs become too expensive; it also gives the government the

right to override decisions made by the Medicines Control Council if necessary.

Pharmacists have been hit by a third bill, which states that pharmacies no longer have to be owned by pharmacists. The move could open the door to competition, especially in big cities, where supermarkets may get licences to operate pharmacies. □

Action zones will modernise the NHS

Linda Beecham, *BMJ*

The British government has earmarked over £30m (\$48m) to establish up to 10 health action zones in England to break down barriers between health and social care (5 July, p 7).

Health authorities will be encouraged to work more closely with social services departments and to form partnerships with local businesses, community groups, and voluntary organisations. Once set up the action zones will take responsibility for coordinating local health interests, agreeing a health strategy, addressing the causes of ill health, and reducing health inequalities.

Authorities are being invited to put in bids by 23 January 1998, and the zones will start in April. The first zones will share £4m from the Department of Health in their first development year, and £30m will be distributed to health authorities for joint spending with other participating agencies in 1999. The health action zones are expected to last between five and seven years. They are likely to have access to capital funding, including money from the private finance initiative, and to support from the national lottery for healthy living centres.

The health minister, Alan Milburn, said that the zones would be "at the forefront of our plans to modernise the NHS. They will be the trailblazer for a new approach to more integrated care for patients.... Better housing, healthy schools, and healthy workplaces could all be a focus for joint initiatives." The government hopes that the plans will include one stop resource centres for GPs, nurses, opticians, pharmacists, and others to be under one roof.

The general secretary of the Royal College of Nursing, Christine Hancock, said that the proposal offered "an enormous opportunity to improve public health." She said that they "could bring an end to barriers between community, social, and hospital services." □

Norwegian doctors attacked over "élite" trade union

Sandra Goldbeck-Wood, *BMJ*

Norwegian doctors have broken with their former trade union to create a new organisation representing the interests of doctors and other academics, the Norwegian Medical Association announced on the eve of its recent annual conference in Bergen. The move has provoked criticism from the press and from the old union.

The former trade union, the Joint Academics Association, included both academics in non-medical professions and other health professionals, such as nurses and physiotherapists. The new breakaway union, Academics, will include only groups with at least three years of academic training.

The Norwegian Medical

Association took the initiative in breaking away, and after a year of secret negotiations with the authorities doctors have now been joined in the new union by lawyers, dentists, architects, veterinary practitioners, economists, and civil engineers.

The prime goal of the new union is to fight for higher pay for better educated groups, starting with newly qualified academics, according to the union's leader, Dr Einar Madsen. "The new organisation will work for a differentiated, market oriented approach to income negotiations. We are making no secret of our goal to achieve greater income differentials between different groups of employees."

The Norwegian Medical

Association had become disillusioned with a relative decline year on year in the incomes of better educated groups during its membership of the Joint Academics Association.

The move represents a break with a long tradition of egalitarianism and social solidarity in Norway and has been heavily criticised by Norwegian newspapers. But the Norwegian Medical Association believes that it will strengthen professional autonomy and encourage economic competitiveness. "There needs to be a greater political and cultural acceptance of differentiation between educational groups in society, so that qualifications are better recognised as a basis for income differences. Income differences must be used actively to channel society's skills into areas where they are most needed," argued the association's leaders in a discussion document produced for the annual conference. □