Europe agrees complete ban on tobacco advertising by 2006

Rory Watson, *Brussels*

All tobacco advertising in the European Union will be gradually scaled down from 2001 and banned completely five years later under a landmark agreement reached by European Union health ministers last week.

Although many antitobacco organisations would have liked the new legislation to have been even stricter (it allows several temporary exemptions) and to have come fully into force earlier, they have still welcomed the breakthrough in the long running negotiations. "Obviously we would have much preferred a shorter time scale," said Andrew Hayes, EU liaison officer for the Association of European Cancer Leagues. "However, it has taken several years to get this far, without knowing that the directive would be implemented."

The agreement, which ended almost six years of stalemate between EU governments, was a personal triumph for the social affairs commissioner, Padraig Flynn, himself a former smoker. "We can now look forward to the day when advertising and sponsorship of tobacco products will not be able to influence young people to take up the habit," he said.

In addition to the implications for public health, the new legisla-

tion is seen as essential to ensure that the single market—one of the EU's fundamental objectives—is not put at risk by differing national rules on tobacco advertising and sponsorship.

The chances of an agreement arose earlier this year with the change of government in Britain and the new Labour administration's commitment to a ban on tobacco advertising. It was also strengthened by a similar change of heart in Greece, where the government placed health concerns ahead of the interests of its large tobacco producing constituency. And days before the EU's move, Belgium banned tobacco advertising.

Despite the opposition of the German and Austrian governments and the abstention of Spain and Denmark, the agreement is now set to be finally endorsed by the European parliament. Member states will then have three years to put it on the statute books.

There will be a further one year for phasing out advertising in the printed media and two years for phasing out sponsorship. Largely because of British insistence and with Formula One motor racing in mind, there will be a further three years (up to 2006) during which it will be possible for tobacco companies

Health ministers Tessa Jowell (UK) and Bernard Kouchner (France)

to sponsor world level events and activities, provided that the sums involved decrease from one year to the next.

The new legislation will still allow advertising inside shops and at points of sale for cigarettes and cigars and will permit tobacco trade publications and the import of publications from outside the EU that contain tobacco advertising. Individual EU governments may also introduce stronger national legislation.

Research by the International Union Against Cancer suggests that advertising bans do affect tobacco consumption. It examined four bans introduced

between 1975 and 1993 in Norway, Finland, New Zealand, and France and calculated that per capita consumption in the various countries had fallen by between 14% and 37%. The World Health Organisation confirms that tobacco is the single greatest cause of preventable disease and death. In the EU alone, 91% of lung cancers in men are caused by tobacco smoke and over 500 000 deaths are related to tobacco annually.

The measures have been strongly criticised by the tobacco industry, which had lobbied long and hard against the legislation. □

AMA chief forced to resign

Charles-Gene McDaniel, *Chicago*

The executive vice president of the American Medical Association, Dr P John Seward, has been forced to resign after the furor surrounding its aborted deal with Sunbeam Corporation. The deal would have provided the associa-

tion with royalties in exchange for the endorsement of a range of products such as blood pressure monitors and thermometers (23 August, p 445).

Dr Seward's resignation was announced just before he was due to face angry members at the association's delegates meeting in Dallas. He is the fifth high ranking executive to have resigned in the fallout from the controversial deal. The association's unilateral cancellation of the contract has

resulted in a \$20m lawsuit by Sunbeam.

Five resolutions relating to the Sunbeam controversy were tabled for the delegates meeting. One of them called for the resignation of both Dr Seward and Dr Thomas Reardon, chairman of the board of trustees, who ordinarily would succeed the chief executive officer on an interim basis.

Dr Seward, who took office just over 18 months ago, called

the Sunbeam contract "a serious mistake." He said: "This happened on my watch, and I have always accepted that responsibility.... For the last three months every fibre of my being has been committed to repairing the damage and moving ahead with the work of this outstanding institution."

The American Medical Association earned a surplus of \$14.4m (£9m) in its last financial year. □

In brief

US abortion rate lowest since 1975: The Centers for Disease Control and Prevention report that the rate of abortions in 1995 (the latest data available) was 20 abortions per 1000 live births compared to 24 in the 1980s and early '90s. Possible explanations for the recent drop include reduced access to abortion services, attitudinal changes towards abortion, and a reduction in the number of unintended pregnancies.

Royal commission will examine long term care in elderly: Sir Stewart Sutherland, principal of Edinburgh University, is to head a royal commission on funding long term care for elderly people in Britain. It will report within a year.

FDA approves irradiation of red meat in US: The Food and Drug Administration has concluded that irradiation effectively kills bacteria such as *Escherichia coli* O157 and salmonella but does not make the food radioactive or change its taste, or nutritional content.

Healthcare spending in east Asia will have increased eightfold by 2025: A report from the Economist Intelligence Unit says that an ageing population in east Asia as well as rising affluence and growing incidence of chronic disease means the region's total healthcare expenditure could expand to \$1.5tn by 2025.

Bill for traffic accidents to be clawed back from insurance companies: An official recovery unit is to be set up to reclaim the millions of pounds owed by insurance companies for treating victims of past road traffic accidents in England. The emergency treatment fee of £21.30, at present claimed by hospital doctors and GPs, is to be dropped.

MRC says there is no sex bias in funding rounds: After studying the success rates for grant applications and fellowships according to the sex of applicants, the Medical Research Council says that it is satisfied that women applying for funding are treated fairly. A similar study in Sweden showed clear evidence of bias against women (31 May, p 1570).

UK government bans sale of beef on the bone

John Warden, *London*

New restrictions on beef to keep bovine spongiform encephalopathy (BSE) out of the food chain are being imposed by the British government in response to fresh scientific evidence of infectivity. Tissue of the dorsal root ganglia within the spinal column is now suspect. As a result, a ban will be imposed on beef sold "on the bone," such as T bone steaks.

In addition, the government is considering a public inquiry into the whole BSE episode, going back to the early 1980s, when British cattle were fed sheep protein probably contaminated by scrapie. The inquiry, by a judge rather than a scientist, would examine the degree of complacency or concealment about the risk of human infection of Creutzfeldt-Jakob disease, first admitted by the previous Conservative government 21 months ago.

Its Labour successor, by contrast, risks being accused of overreaction to advice from the Spongiform Encephalopathy Advisory Committee (SEAC), which met on 2 December. The next day the agriculture minister, Jack Cunningham, announced that he was banning beef on the bone "on a strictly precautionary basis."

He said that new evidence had emerged from an experiment designed to check which parts of cattle may have BSE infectivity. Animals fed large doses of BSE by mouth showed infectivity in the dorsal root ganglia. The research has not yet been published but has been submitted to *The Veterinary Record*. Further new findings still being evaluated indicate that infectivity may also be found in bone marrow in cattle at a very late stage of the disease.

In both cases the experimental animals showed the infectivity only at ages over 30 months, above which all cattle are already excluded from the food chain. Tests on muscle, meat, and blood in the same experiments were negative. SEAC emphasised that the risk is very small. It advised either leaving consumers to choose what precautions to take or requiring

all beef to be boned before being sold.

Choosing the second option, Dr Cunningham said that in taking account of the views of the chief medical officer, Sir Kenneth Calman, he had concluded that it would not be acceptable to allow tissue shown to transmit BSE to remain within the human food chain. Risk is estimated on the basis that 5% of dorsal root ganglia in cuts of meat on the bone may be eaten by the consumer, usually in the action of gnawing or scraping the bone. The new restriction applies to beef from cattle over 6 months old, whether from Britain or imported. Although only about 5% of beef is consumed on the bone, it is a further blow to the British beef industry at a time when prices have slumped and farmers are taking protest action against cheap imports. □

UNITED NORTHERN PHOTOGRAPHERS

Tissue within the spinal column is now suspect

GPs should have access to spirometry for assessing COPD

Kamran Abbasi, *BMJ*

Spirometry is more accurate than peak flow measurement for assessing chronic obstructive pulmonary disease, say new guidelines from the British Thoracic Society. They recommend that all patients suspected of having the disease should be offered spirometric testing by their general practitioners (*Thorax* 1997;52(suppl 5):S1-S2).

Dr Mike Pearson, chairman of the committee that produced the guidelines and consultant physician at Fazakerly Hospital

in Liverpool, said: "Chronic obstructive pulmonary disease is far too frequently misdiagnosed and undertreated. Many people with early chronic obstructive pulmonary disease put their symptoms down to a smoker's cough. If patients are identified early and can be persuaded to stop smoking, they can halt the progress of the disease."

Chronic obstructive pulmonary disease is an umbrella term covering chronic bronchitis, emphysema, chronic obstructive

airways disease, chronic airflow limitation, and some cases of chronic asthma. In patients with chronic obstructive pulmonary disease, impairment of lung function is, at best, only partially reversed by bronchodilator therapy.

The main drawback is the inadequate access to spirometry. Although it is feasible for each patient to have a peak flow meter, spirometers are more expensive, and trained staff are needed to perform the test. As most general practices do not have a spirometer, other options are to offer open access spirometry at hospitals, provide spirometry at individual practices, or organise a mobile community spirometry service. □

White paper puts GPs in the driving seat of the new NHS

The British government views its new 10 year plan, outlined this week, as a turning point for the NHS. The white paper *The New NHS* gives control of most of the NHS budget to GPs and community nurses, writes **John Warden**

The new NHS, foreshadowed in the white paper, will build on what has worked and discard what has failed. It is the basis of a 10 year programme of "evolutionary change rather than organisational upheaval." There will be no return to Labour's old command and control system. But there will be an end to the competitive internal market, introduced by the Conservatives; in its place will be a system of "integrated care" based on partnership driven by performance. The government believes that "what counts is what works."

Many features of the internal market will survive. For example, the separation between the purchase and provision of hospital care will be retained; cooperation, however, will replace competition. Local doctors, nurses, and health authorities will have new powers to commission services and ensure that the local NHS is built around the needs of patients. Health authorities will have a powerful supervisory role with greater input from local councils. NHS trusts are to remain in their present form as providers. The approach is described as interdependence rather than independence.

More attention will focus on the quality of care and less on the finance. Trusts will have to publish the costs of treatments to expose inefficiency. National standards of care will be guaranteed. Savings on bureaucracy will redeploy £1bn (\$1.6bn) into frontline care. Computer technology, including telemedicine, will be diverted from administration to patient care. A nurse led telephone helpline, NHS Direct, will advise patients on self treatment round the clock.

A key feature will be the jointly agreed local "health improvement programme." This will govern the actions of all parts of the local health service and set out the strategy for improving health care. Health authorities will monitor the implementation of the health improvement programme, with reserve powers to ensure that major new buildings and medical staffing appoint-

Tony Blair said: "I want the NHS once more to be the envy of the world"

Key components of the 10 year plan for NHS

- A Commission for Health Improvement will oversee the quality of clinical services
- A National Institute of Clinical Excellence will promote clinical cost effectiveness
- A national schedule of reference costs will measure efficiency of the NHS trusts
- A national service framework will examine the best ways of providing particular services
- Health improvement programmes will improve health care locally
- Primary care groups will bring together GPs and community nurses to commission health care
- An Advisory Committee on Resource Allocation will distribute NHS cash more fairly
- An annual survey of patients' and users' experience will compare performance
- A task force will involve NHS staff in shaping new patterns of health care

ments are consistent with it.

Health authorities will devolve responsibility for direct commissioning of services to new "primary care groups" comprising all GPs in an area together with community nurses. They will replace fundholding in 1999. In the meantime there will be no new admissions to the fundholding scheme. In time, health authorities will withdraw from commissioning, and primary care groups will have the opportunity to become free-standing primary care trusts.

For alignment of clinical and financial responsibility, primary groups will take devolved responsibility for a single unified budget.

Each group will have available their population's share of resources for hospital and community health services within a "single cash-limited envelope." In future one stream of cash limited funds will flow through health authorities to primary care groups. Although there will be concern about cash limiting general medical services, the white paper says that the new arrangement will give GPs the maximum choice of treatment options.

The paper says: "For the first time in the history of the NHS, all the primary care professionals, who do the majority of prescribing, treating and referring, will have control over how resources

are best used to benefit patients The argument between fundholding and non-fundholding is yesterday's debate. The time has come to move on, taking the best of both approaches."

Groups rather than individual practices will reach service agreements with NHS trusts about the quality and level of hospital care. Over time, the groups will extend indicative budgets to individual practices for the full range of services. Initially every practice will have a prescribing budget, as most do now. Extracontractual referrals will be abolished, but GPs who need to make personalised arrangements to meet a patient's special clinical needs will be able to do so.

Health authorities, however, will clearly retain a powerful role. Primary care groups will be accountable to them and will work within the health improvement programme. The authority will have power to withdraw freedoms from groups that get into serious difficulty.

Trusts will be accountable to NHS regional offices. Besides rigorous scrutiny of their costs and performance, trusts will be assessed against the wider goals of improving healthcare outcomes.

A stated aim is to renew the NHS as a one nation health service. Closer integration of health and social care, with pooled budgets, is envisaged. Statutory duties of partnership placed on NHS bodies to work together will extend to local authorities, whose chief executives will participate in meetings of the health authority.

And although market forces are eschewed, primary care groups will be expected to bear down on trusts' costs to achieve value and to change providers.

The white paper calls it a tough and challenging programme, parts of which may be a long haul and take time to show visible improvement. But the end result, it says, will be an NHS that gets better every year and is modern and dependable. □

The New NHS is available from the Stationery Office, price £12.50.

Report urges widespread reform of handling of NHS data

Douglas Carnall, *BMJ*

Personal health data flow freely from clinical to administrative settings in the NHS, and action is required to ensure confidentiality, says an independent review group chaired by Dame Fiona Caldicott.

Dame Fiona, principal of Somerville College, Oxford, and a past president of the Royal College of Psychiatrists, was asked to lead the review after the BMA advised doctors not to cooperate in the development of the NHS "net" two years ago. This followed concerns about the increased potential for breaches of security in an already vulnerable system.

In the review, investigators mapped 86 flows of patient identifiable information for non-clinical use in the NHS, and found that, although all flows were justified, there was "variable awareness" of the requirement for confidentiality outside the clinical setting and a need to reduce information that can identify individuals to a minimum.

Information technology professionals privately admit that the current NHS systems are vulnerable to external breaches by hackers and to unauthorised use of data by internal staff. One trust's information technology

director said: "It's only a matter of time, before, say, the names of all the women in Yorkshire taking the pill are published on the internet."

The report makes 16 recommendations designed to increase awareness of the problem, agree national frameworks and protocols, and implement technical safeguards such as replacing patients' names and addresses with the NHS number. Health organisations should nominate a senior health professional to act as the guardian of patient confidentiality, and an accreditation

system will encourage good practice. A steering group will be set up to develop the administrative framework governing access to confidential patient information and to look at technical ways of protecting patient confidentiality.

Dr Sandy Macara, chairman of the BMA's council, expressed delight that the department had recognised doctors' concerns at the threat to privacy posed by the increasing use of information technology. "There is still much to be done, but we can all now see where the start line is." But Dr Fleur Fisher of the Campaign for Medical Privacy said: "The professions are generating personal data that can flow in any direction. Two years after the BMA first dug its heels in, we still have databases built in an unacceptable and unethical way." □

Personal health data often flows freely within the NHS

South African row over denial of dialysis

Pat Sidley, *Johannesburg*

South Africa's constitutional court has ruled that there is no automatic right for poorer patients—who have to rely on the state's stretched resources—to expensive treatment such as kidney dialysis. The ruling has inflamed the row over lack of resources for health care for poor people.

The case was brought by 41 year old Thiagraj Soobramoney, who collapsed after being handed the results of the court ruling. He died two days later, apparently after a stroke.

Mr Soobramoney had been

refused dialysis by the Addington Hospital in Durban because he had other health problems, including heart disease and diabetes. Because of scarce resources, the hospital's policy is that prospective patients for dialysis should be admitted for treatment only if they qualify for transplants.

After an unsuccessful application to the Durban High Court Mr Soobramoney asked the Constitutional Court to compel the hospital to provide him with free dialysis treatment. His case was based on the constitution's guarantee to a "right to life" and on statements by the department of health that patients could not be denied emergency medical treatment.

The court rejected these arguments, saying that to provide this service would make it impossible for the state to fulfil its other

constitutional health obligations.

The court added: "It would also have the consequences of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for preventative health care and medical treatment for persons suffering from illnesses which are not life-threatening."

The president of the court, Arthur Chaskalson, said: "The hard and unpalatable fact is that if the appellant were a wealthy man he would be able to procure such treatment from private sources; he is not, and has to look to the state to provide him with treatment." He described the disparities of wealth and resources in the country and said that for as long as they continued the aspirations of South Africans to human dignity, freedom, and equality would have "a hollow ring." □

Doctors stage hunger strike in Australia

Christopher Zinn, *Sydney*

The Australian government has given in to a hunger strike by overseas trained doctors and promised 100 extra university places to help them meet Australian standards if they agree to work in rural areas where there is a shortage of doctors.

The climbdown came after 40 doctors staged a three week hunger strike outside state parliaments in New South Wales and Victoria against what they claimed were overly stringent registration tests. Eight had to be taken to hospital.

But health minister Michael Wooldridge said there would be no compromise on the standards of care needed by the doctors to practise unsupervised in Australia. The extra 100 places represent a one-off increase which will begin next year.

The Australian Doctors Trained Overseas Association claimed that the Australian Medical Council examination they had to pass was a form of "medical apartheid." They said that it discriminated against their 1146 members, who are mainly from non-English speaking backgrounds. Their hunger strike was suspended on 5 December only after the government offered peace talks. The association's president, Dr Asaad Razaghi, said that although they would accept the government's offer, the plan for 100 places for 1100 doctors—who are currently either unemployed or working in jobs such as cleaners and taxi drivers—was not enough.

"Dr Michael Wooldridge has to go beyond this point because we are prepared to work in the bush, but what we need actually is a refresher or retraining programme because we believe we have been deskilled purposefully and deliberately by the medical apartheid in this country," he said.

The overseas doctors will sit the same exams as local students and be required to undertake the same postgraduate training before being given the vital Medicare provider numbers which enable them to practise as GPs. □

Difference in life expectancy between rich and poor is widening

Kamran Abbasi, *BMJ*

Men in affluent Cambridge and Surrey live almost seven years longer than men in Manchester, Liverpool, and in inner London, according to a study published this week. The data also showed that although women live longer than men in all areas the difference is most marked in poorer parts of the country.

Researchers from the National Institute of Epidemiology at the University of Surrey analysed mortality data for English health authorities from 1984-94 and found that life expectancy was related to sex and socioeconomic factors (*Journal of Epidemiology and Community Health* 1997;51:649-58).

Dr Veeni Raleigh, one of the authors and a senior research fellow in epidemiology, said: "Life expectancy, as a measure of mortality, is very useful—not as a forecaster of how long people are going to live but as a snapshot of mortality. The five most deprived health authorities had the lowest male life expectancies, and there is a north-south gradient, aside from inner London."

Using Jarman deprivation scores, derived from demographic and socioeconomic variables based on the 1991 census, the researchers note that prosperous areas, such as Cambridge, Surrey, and Bromley, have the highest life expectancies. By contrast, deprived areas like Liverpool, Manchester, and parts of inner London—namely Camden and Islington, East London and the City, and South East London—have the lowest life expectancies.

Average life expectancy is 74.1 years for men and 79.5 years for women, with the gap between the sexes more marked in deprived areas. For example, Manchester has the lowest life expectancy in England and the widest gap between men and women, whose life expectancy is 69.9 years and 76.7 years respectively. This may be explained by the preponderance of coronary artery disease, lung cancer, and suicide in men from deprived areas. Deprived areas also have substantial ethnic minority populations.

The investigators add that deprivation also correlates with

Life expectancy among men in England is poorer in the north

trends in life expectancy. Prosperous areas had the largest increase in life expectancy over the study period, whereas deprived areas showed minimal improvement, widening the gap between the

rich and the poor. The next step, suggests Dr Raleigh, is to analyse cause specific mortality in different age groups to identify the reasons for this variation in life expectancy. □

Drug company loses battle to stop article

Sandra Goldbeck-Wood, *BMJ*

The pharmaceutical company Merck Sharpe and Dohme lost its battle in the Norwegian courts to stop the publication of an article that criticised one of the company's products.

The article, due to be published in the journal of Norway's medicines control agency, *Nytt om Legemidler*, had been halted by a temporary injunction granted on 22 October, which the court overturned last week. But the judge did not require Merck Sharpe and Dohme to pay the agency's legal costs because of the important matters of principle raised by the case.

The disputed article is a critical economic analysis of the osteoporosis drug Fosamax,

which is currently used in the secondary prevention of osteoporotic vertebral fractures. The article warns against extending the use of Fosamax to the prevention of hip fractures, pointing out that the absolute risk reduction for femoral neck fracture with Fosamax use is only 1%, according to a randomised controlled trial of 2027 American women. This means that 91 women would be needed to be treated with the drug for three years each to prevent a single fracture. This does not justify the hundreds of millions of Norwegian kroner it would cost to treat the 20 000 or more patients at increased risk of hip fractures, says the article. Merck Sharpe and Dohme has previously been criticised in an article in the Norwegian Medical Association's medical journal for emphasising only the relative risk reduction of 51% shown in the same study.

Merck Sharpe and Dohme sought the injunction because it claimed the report was inaccurate, biased, and prejudicial to the company's economic interests.

"The inaccuracies and bias in this report would have been picked up in a journal with independent scientific quality control, but this is a journal with no peer review and no correspondence column. By contrast, Merck Sharpe and Dohme, as a research based company, bases its information to doctors on publications in open, peer reviewed journals," said Egil Bodd, administrative director of Merck Sharpe and Dohme Norway.

Judge Stein Eikvåg said in his report: "The agency has both the right and the obligation to assert its views, but when it happens in the form of a specialist article in their own informational magazine for which they are basically the only ones who provide the material, the views will be understood as state information with the weight this carries, and then it becomes unfortunate if the message is not factual and objective." □

Ethical guide for surgeons is launched

Kamran Abbasi, *BMJ*

Surgeons should advise patients as if they were treating themselves or family members. Moreover, they should not allocate scarce resources on the basis of social status, class, or other personal attributes, according to a report from the Senate of Surgery of Great Britain and Ireland.

The surgeon's duty of care. Guidance for surgeons on ethical and legal issues says surgeons work in environments where they often need to make urgent decisions with potentially far reaching implications. New developments and advances in technology, although presenting new opportunities, may also give rise to new moral dilemmas. □

Herpes virus linked to multiple sclerosis

Deborah Josefson, *San Francisco*

Researchers at the National Institute of Neurologic Disorders and Stroke in the United States have uncovered more evidence linking the herpes virus to multiple sclerosis (*Nature Medicine* 1997;3:1394-7).

Epidemiological studies have pointed to a link between multiple sclerosis and early childhood exposure to an infectious or environmental agent. Herpes viruses are good candidates because they stay in the body for a long time and affect the neurological system. Typically, they cause an initial infection in infancy or childhood followed by a reactivated syndrome later in life. For instance, varicella zoster causes chicken pox in childhood and shingles in the immunocompromised adult. Recently discovered herpes

viruses have been implicated in Kaposi's sarcoma (HHV-8) and in roseola or exanthem subitum (HHV-6)—a reticular rash with fever occurring in infancy.

Acting on the recent demonstration that copies of HHV-6 are present in plaques in multiple sclerosis, the investigators screened serum samples of 102 people, 36 of whom had multiple sclerosis (of whom 22 had the relapsing-remitting type and 14 the chronic progressive form). Of the patients with relapsing-remitting multiple sclerosis, 73% carried antibodies to an early antigen of HHV-6, compared with 18% of normal controls. Overall, 35% of patients with multiple sclerosis had antibodies to the HHV-6 early antigen; moreover, the serum of 30% of patients with the disease carried the DNA of HHV-6, a marker for active HHV-6 infection. In contrast, none of the normal controls tested positive for HHV-6 DNA.

Although these findings may be merely circumstantial, they do show the strongest association between a specific virus and

Herpes viruses stay in the body for years

multiple sclerosis seen so far. Dr Steven Jacobson, principal investigator of the study, said: "We've suspected a possible role for a virus in multiple sclerosis for quite some time, and these results certainly point to this particular virus. But we need to know more before we move to the clinical stage. We've thought for a long time that genetics, an autoimmune factor, or something in the environment—like a virus—might cause multiple scle-

rosis. One can certainly make a case for a combination of these factors—namely, that a small group of individuals may be genetically susceptible to a virus. If HHV-6 is really behind multiple sclerosis then we also need to know why infection with such a common virus causes disease in so few people." Additional testing for the presence of HHV-6 in patients with multiple sclerosis is under way to strengthen the link. □

Canada creates new national blood service

David Spurgeon, *Quebec*

Canada is to get a new national blood service as a result of the work of a commission of inquiry into a scandal that left thousands of Canadians infected with HIV and hepatitis C from transfusions.

The four year inquiry cost around \$C57m (£25m; \$40m) and embroiled governments, pharmaceutical companies, the Canadian Red Cross Society, and hundreds of individuals in bitter controversy. In the report the commissioner, Mr Justice Horace Krever, called for the new system to be independent and accountable to the public, with a mandate to put safety first.

The federal government responded immediately by creating the Blood Safety Council, headed by a haematologist, to advise on safety measures and to see that the commissioner's 50 recommendations are implemented.

Medical scientists had complained that the old system, run by the Red Cross, placed more emphasis on the advice of administrators than on that of scientists. Judge Krever said that the problem with the old system was that nobody was in overall charge. He recommends a new board of directors that would contain no politicians or Red Cross representatives. He also calls for blood and blood products to be paid for directly by hospitals, rather than through a budget set by provincial politicians.

Federal health minister Allan Rock congratulated Judge Krever for his "remarkable work." He also apologised to victims of the blood scandal on behalf of the government, as did the Red Cross—neither of whom had done so before. In fact the federal government, the Red Cross, and some pharmaceutical companies had tried through court action to prevent Judge Krever from laying blame for the tragedy in his final report.

The report also says that all patients who have been, or are in the future, infected through the blood service should be compensated. □

Diabetes drug withdrawn after reports of hepatic events

Jacqui Wise, *BMJ*

The new diabetes drug troglitazone (Romozin) has been withdrawn from the market in Britain after an increasing number of reports of severe hepatic adverse events. The Food and Drug Administration in the United States, however, has decided that the benefits of treatment outweigh the risks, provided that patients receiving troglitazone are monitored frequently for signs of liver injury.

Among the 5000 patients who have been treated in Britain with the drug since it became available on 1 October 1997, there has been only one reported case of liver dysfunction. The Medicines Control Agency said, however, that there have now been over 130 reports worldwide of hepatic reactions to troglitazone. Reactions have included severe hepatocellular damage, hepatic necrosis, and hepatic failure, and six people have died. About 370 000 patients worldwide have been treated with

troglitazone for at least three months—the mean time to onset.

GlaxoWellcome, the company that markets the drug in Britain, said that it had made the voluntary decision in association with the Medicines Control Agency because it felt that the incidence of adverse events cannot be predicted accurately and because at present there were no clear risk factors for the development of hepatic events which would allow the drug to be used safely in some patients.

By contrast, in the United States the Food and Drug Administration said that the benefits outweighed the risks for treating appropriately selected and monitored patients with type II diabetes with troglitazone. The administration recommends that such patients should be monitored more frequently for signs of injury to the liver and that warning information should be displayed more prominently on the drug's labelling. □