Mitterand book provokes storm in France

The general practitioner who treated France's late president François Mitterand from 1969 to 1994 is under threat of being barred from medical practice for breach of medical secrecy. Dr Claude Gubler also faces being fined Fr300 000 (£40 000) and condemned to one year's imprisonment by a criminal court.

Last week further sales of Dr Gubler's book, *The Great Secret*, published days after Mitterand's death, were banned by Paris judge Jacqueline Cochard after an emergency procedure started by President Mitterand's family on charges of violation of privacy and medical secrecy.

President Mitterand died on 8 January, at the age of 79. *The Great Secret*, jointly written with a journalist, went on sale on 17 January having been featured, with excerpts and unofficial photographs of the president lying in state, the previous day by the popular weekly magazine *Paris-Match*.

The book stated that the president was diagnosed with cancer of the prostate and bone metastases as early as 1981 but that the diagnosis was kept as a "state secret" despite President Mitterand's promise of transparency regarding his health.

The cancer was revealed to the public only late in 1992, and Dr Gubler asserted that "In November 1994, I considered François Mitterand no longer capable of carrying out his duties." (French officials denied that he had been incapacitated, and even the prime minister, Alain Juppé, a conservative who served as foreign minister under the Socialist president, said: "I never found him in a state of impairment.")

Dr Gubler said that he started his book in August last year because he wanted to reveal the truth behind the incomplete medical bulletins issued in his name over several years. He said that he and Dr Adolphe Steg, a urologist, had regularly given President Mitterand radiation and chemotherapy since 1982, when the already advanced stage of cancer led to the pessimistic prognosis of a survival time of about three years.

In November 1994, wrote Dr Gubler, the president came to work at about 9.30 or 10 am and spent most of his days in bed. "He was not working because nothing interested him except his disease."

At the end of 1994, after voicing doubts about the president's capabilities, Dr Gubler was dismissed, and President Mitterand was treated by a doctor specialising in homoeopathy and by Dr Jean-Pierre Tarot, a pain

Mitterand's funeral has been followed by accusations of breaches in medical confidentiality

specialist, who became his personal physician and stayed with him until his death.

On the day of the publication, Mr Mitterand's family sued to have the book banned. The court pronounced the ban the next day, 18 January, but by then about 40 000 copies had been sold. On the same day, the French medical association announced that it would take disciplinary action against Dr Gubler for violation of medical secrecy. In theory, the association could forbid Dr Gubler from practising medicine—but Dr Gubler no longer does. He has given up private practice and is a member of the French social affairs inspectorate, a position he owes to President Mitterand.

As to possible criminal charges, French law provides for a maximum fine of Fr 300 000 and a year's imprisonment. But judges are unlikely to go beyond the ban imposed on the book.

The whole affair has stirred widespread public and parliamentary debate about a possible compromise between the strict French interpretation of medical secrecy and the right of the public to be informed of health problems that may hamper the chief executive's capabilities to carry out his duties.—ALEXANDER DOROZYNSKI, *medical journalist, Paris*

Investigation of sex abuse in Irish hospital expands

The investigation into how a major Irish public funded hospital owned by a Catholic order dealt with allegations of sex abuse by a senior member of its medical staff is being extended, with the approval of the Irish Department of Health.

The inquiry was set up last year amid claims that Our Lady of Lourdes Hospital in Drogheda, County Louth, failed to act promptly after allegations of abuse against young boys attending the hospital, and accusations that they had been subjected to unnecessary examination by a male consultant. The doctor involved had stepped down temporarily after the accusations last March. He retired last October on a pension of £130 000 (£51 000).

The deadline covering the hearing of evidence by the specially appointed external review group was extended to allow further written submissions. The decision follows confirmation from the Drogheda police that the number of formal complaints against the consultant has now risen to 19.

Headlines

US increase in deaths from infectious diseases: Deaths from infectious diseases in the US rose by 58% between 1980 and 1992, with the AIDS virus, respiratory diseases, and blood infections the main culprits, says a report by the Centers for Disease Control and Prevention. The study of death certificates was reported in *JAMA* (the journal of the American Medical Association) and showed that by 1992 the death rate from infectious disease was 65 per 100 000.

Sex determination banned in India: The use of sex determination techniques such as amniocentesis to identify female fetuses for abortion has been outlawed in India. The new law, which came into effect on 1 January, also prohibits informing pregnant women or their relatives of the sex of a fetus.

Irish nurses may ballot over strikes: Irish nursing unions were earlier this week due to decide whether to ballot members on a series of two day strikes planned for March, April, and May, after a two year deadlock in their pay talks. Late efforts were being made by the Irish Congress of Trade Unions to avert the stoppage. There are 26 000 nurses in the Republic of Ireland.

Dutch claim lowest abortion rates: The Dutch association of abortion clinics has claimed that the Netherlands maintains the lowest abortion rates in the world. The association says in its latest annual report that the rate per 1000 fertile women increased from 5.6 in 1991 to 6 in 1994. The figure for England and Wales is 13.

UK police to get CS sprays: CS canisters are to be issued to 2500 frontline police in Britain in a six month trial. Training and written guidance will emphasise that only officers facing violence are justified in using the canisters, which send out a jet of CS gas to a range of three metres.

Polio eradication campaign advances steadily: The battle to eradicate polio worldwide by the year 2000 is making good progress, says the World Health Organisation. The organisation reports that some 300 million children received supplementary immunisation against polio in 51 countries around the world last year.

Last week the Irish Medical Council set up an inquiry into the case. Under Irish law the sworn inquiry being undertaken by its fitness to practise committee will have similar rights and privileges as those held by the Dublin High Court. The council was criticised by a Labour member of the Irish parliament, Brian Fitzgerald, who said that the inquiry should have been instigated as soon as the allegations became known.

Last summer files on two initial cases were sent to the director of public prosecutions, but owing to lapse of time since the alleged offences occurred it was decided not to prosecute. It was confirmed that two of those who have made complaints against the consultant have agreed to testify before the medical council's inquiry.—ALAN MURDOCH, freelance journalist, Dublin

Steep rise reported in meningococcal infections

Notifications of meningococcal infections rose sharply in 1995, according to last week's *Communicable Disease Report* (vol 6, No 3). Over the previous four years the number of cases notified to the Office of Population Censuses and Surveys has been fairly steady at around 1400 cases a year, but more than 1800 cases are reported in the preliminary data for 1995. Deaths attributed to the disease in 1995 rose to 185 compared with 148 in 1994, though the crude case death rate has fallen slightly from around 12% to 10%.

Dr James Stewart, a consultant epidemiologist for the Public Health Laboratory Service, could offer no explanation for the rise. "Meningococcal disease has a winter peak in its incidence, and this year the rise has been earlier and higher than usual," he said.

"The figures have shot up in the last couple of months, which is unusual but does happen sometimes, and the rise has been sustained. There has been a rise in both types B and C of meningococcal disease."

Dr Ed Kaczmarski, a consultant microbiologist at the Public Health Laboratory

Notification of meningococcal disease in England and Wales

Service's meningococcal reference unit in Manchester, also notes that much of the rise is in notifications of septicaemia.

"To the lay person, meningitis is the dread word, but it is the septicaemic form of the illness that is really nasty," he said. The chief medical officer's advice to general practitioners back in 1988 to give benzylpenicillin in all suspected cases has probably helped to reduce the death rate from the disease, but it also reduces the chance of culturing the organism by conventional means. So although the number of isolates we are seeing in the reference laboratory is more stable than the number of notified cases, we will have more data from new non-culture diagnostic techniques, such as polymerase chain reaction, within a couple of months."

Meanwhile, in the Republic of Ireland health minister Michael Noonan is to appoint an expert study group to investigate increasing numbers of deaths from meningitis in the republic.

Two deaths, both in women living in Dublin, have already been reported this year, compared with 13 deaths from the disease in the first six months of last year—the same number as in the whole of 1994.

The total number of cases of meningococcal disease in the republic rose from 241 in 1994 to 375 last year.—DOUGLAS CARNALL, *BMJ*

US teaching hospitals pay row

The 1200 teaching hospitals in the US were given notice last week that the federal government would no longer pay for services delivered by trainee doctors. In what is being called the biggest settlement in history, the University of Pennsylvania health system agreed to pay back \$30m (£19m) to Medicare, the US government insurance plan that covers elderly patients and pays for doctors in training.

According to federal rules, Medicare pays for trainees' salaries and for some of their teaching, but it does not pay for the medical services that they deliver. Instead, trainees are supposed to be supervised by senior doctors, who are allowed to bill the government and other insurers. A spokesman for the American Medical Association, Dr Robert Dickler, said that the rules have "a fair amount of ambiguity" about the level of supervision needed to be legitimate. Even federal regulators admit that a grey area exists between what is and what is not "supervision."

But the government is investigating—in addition to the University of Pennsylvania—the University of Florida and at least six other teaching hospitals linked with universities.

America's teaching institutions are already under pressure. Congress is planning major cuts in payments for trainees' salaries, and the private sector's increasing pressures to cut costs are causing hospitals to close beds or shut down—JOHN ROBERTS, *North American editor, BMJ*

Doctors and lawyers unite on incapacity laws

The BMA and the Law Society last week issued a guide plotting a path for doctors and lawyers through the minefield of assessing an individual's mental capacity. It covers a range of issues including ability to consent to a sexual relationship, to refuse or consent to medical treatment or taking part in research, and even to vote.

The guide was launched at a conference hosted by the two professional bodies to discuss the Law Commission's proposals to reform the law affecting mentally incapacitated people. But only three days before, the Lord Chancellor, Lord Mackay, said that the government would not adopt the commission's recommendations but would put out a consultation paper on the issue.

The move followed a scare article in the *Daily Mail* claiming that the reforms would permit euthanasia and the removal of organs without patients' consent. A similar exercise in the *Daily Mail* over the reform of domestic violence laws ended with Lord Mackay being forced to drop the Family Homes and Domestic Violence Bill when it had almost completed its parliamentary passage.

The Law Commission's proposals on mental incapacity would have plugged a legal loophole whereby no one, not even a court, has the power to consent to medical treatment on behalf of patients who are too incapacitated to make their own decisions. The gap was first highlighted in 1988 when parents and doctors sought court sanction for the sterilisation of a mentally handicapped young woman.

The commission proposed a new judicial authority with power to make orders dealing with specific issues and to appoint proxies to take decisions. The recommendations also included a statutory framework for advance directives about future care, although the courts have held that such "living wills" are already legally effective.

The guidance from the BMA and the Law Society reminds doctors that, although close relatives are usually consulted about what a mentally incapacitated patient would have wanted, getting a relative to sign a consent form is unnecessary and has no legal effect.

The guide emphasises that the doctor must assess the patient's capacity in relation to the decision or activity in question. In the case of medical treatment, for instance, can the patient understand the nature and effects of the treatment and the consequences of not having it?

The High Court has held that a schizophrenic patient in Broadmoor was capable of deciding that he did not want his gangrenous leg amputated. His decision was an advance directive given when he was capable and had to be respected if he lost capacity in the future.—CLARE DYER, *legal correspondent, BMJ*

Assessment of Mental Capacity: Guidance for Doctors and Lawyers, a joint report of the BMA and the Law Society, is available from the BMA, price £8.95.

German doctors are not all that keen on coding

German doctors protest against coded diagnoses

More than 30 000 doctors in Germany have signed a declaration of protest against a new law requiring them to indicate their diagnoses by code number rather than by name in insurance claims. The new law, introduced on 1 January, obliges doctors to use code numbers from the World Health Organisation's International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) instead of words, such as "diabetes" or "migraine," in their settlement claims.

The new rule is intended to facilitate the processing of patient data by computers and to achieve more cost transparency and better quality control in the public health insurance system. Without diagnoses defined by ICD-10 code numbers, health insurers will, in six months' time, no longer have to refund treatment costs to doctors. Germany is said to be the first country to have introduced the code numbers in care of ambulant patients.

The doctors protesting against the law say that it could mean a lot of more work for them. Finding out the correct code number from a huge catalogue containing 14 000 numbers takes at least two minutes for each diagnosis, which in a doctor's practice could amount to more than 300 extra working hours a year. The doctors also fear that the introduction of more and more detailed diagnostic specifications could violate patients' rights because the code numbers could make it easier for insurers and employers to identify high risk patients, such as those with AIDS or with a history of drug dependence, psychiatric disease, or attempted suicide.

On the other hand, the doctors argue that in some cases the codes may be insufficient

to provide an exact definition of a syndrome—for example, of shoulder pain of unknown origin, for which only one ICD diagnosis, "shoulder lesion," is available. This diagnosis, they say, would be misleading in most cases.

German health minister Horst Seehofer said that doctors' professional groups had participated fully in negotiations during the three year preparation period for the new law. Seehofer also pointed out that hospital doctors had been using the the previous ICD-9 codes since 1986 without apparent problems. Nevertheless, in new negotiations with insurers and doctors Seehofer agreed to have the new system of using ICD codes reviewed. The section of the ICD-10 code book that was designed only to describe patients' social circumstances has been suspended for use in medical diagnoses.

—HELMUT L. KARCHER, *medical writer, Munich*

Israel relaxes laws on food supplements

Israel is to relax its regulations on the advertising and marketing of vitamins, minerals, and other food supplements. Existing rules are so stringent that they are disregarded by manufacturers, importers, and advertising agencies.

Newspapers and magazines in Israel carry advertisements almost daily claiming that food supplements can shrink prostates, darken hair, restore sexual potency, cure asthma, and bring diabetic patients' blood sugar levels to normal. The health ministry, with a weak legal department and negligible fines, has been able to do little to enforce existing laws that bar food products from making therapeutic claims.

Now health minister Dr Ephraim Sneh has said that vitamin and mineral supplements and other pills may be sold as food products, although manufacturers may not make any health claims. Dr Sneh has also promised to "significantly increase" enforcement efforts and fines.

Until now the law has required all supplements containing twice the US standard recommended daily allowance to be registered as a drug and tested and supervised by the ministry's pharmaceuticals division. Everything else was regarded as a food supplement, under the control of the food service division. Currently, any product found by the division to cause no harm to health has been allowed to carry the statement: "Under licence by the health ministry." This has been wrongly understood by many consumers to be an endorsement of their efficacy.

Under the new regulations, packages and advertisements will have to bear the words: "The health ministry states this is not a drug." The recommended daily dosage and maximum dosage of the product will also have to be listed.—JUDY SIEGEL-ITZKOVICH, medical correspondent, *Jerusalem Post*

Scottish bed crisis leads to review on planning services

A review of planning assumptions for acute medical services is being conducted in Scotland after the cancellation of hundreds of scheduled operations in recent weeks as hospitals have been forced to keep beds free for emergency cases. The influenza outbreak coupled with the effects of extreme winter weather resulted in medical admissions soaring throughout the country. Hospitals in Edinburgh, Glasgow, Dundee, Falkirk, and Stirling all had to cancel non-urgent admissions.

Doctors, health unions, and opposition politicians complained that hospitals had been left with too few beds to cope with such a situation and called for a moratorium on any further reductions pending a reassessment of long term needs.

The Scottish Secretary, Michael Forsyth, saw the problems at first hand during a visit to one of the worst affected hospitals, the Edinburgh Royal Infirmary, where medical admissions were running at 50-60 a day compared with a normal average of between 30 and 40.

He announced the review of acute services later that day after a series of hastily convened meetings with representatives of the BMA, the Royal College of Nursing, and hospital chief executives.

Mr Forsyth said that exceptional difficulties had contributed to the problems, and he rejected claims that the problems were due to cuts in the number of beds. He said, however, that he wanted to ensure that hospitals were capable of coping with high levels of demand for short term acute services.

Michael Forsyth tells hospital staff in Edinburgh that he will be looking into bed shortages

THE SCOTSMAN PUBLICATIONS

The review has been welcomed by health service staff, some of whom are convinced that more beds are needed. Dr Keith Little, consultant in charge of the accident and emergency unit at the Edinburgh Royal Infirmary, said: "If hospitals are working to maximum efficiency for acute beds and there is an unexpected bulge, there is nowhere else to put the patients. The strategy needs to be addressed. The theory of progressively cutting beds is flawed—we need more acute beds."

The number of acute beds in Scotland has fallen from 19 922 in 1981 to 15 160 last year, and the Scottish Office has told the health boards to plan further reductions, which could see the total number fall to around 12 000 by the end of the decade.—BRYAN CHRISTIE, health correspondent, *Scotsman*

High Court rules on trust's power to discipline

The High Court ruled last week that an NHS trust had the power to discipline two doctors for failing to properly diagnose and treat a small boy, even though the trust was not the doctors' employer at the time that the incident happened.

Mr Justice Sedley clarified a "state of confusion" over the effect of the 1994 NHS reforms on managements' powers to discipline hospital doctors for mistakes that predated the changes. The judge said that his ruling would help to resolve legal problems, potentially affecting 2000 doctors.

The case also established that an individual who thinks a public body has misunderstood its powers in taking a decision can seek redress through the courts.

The legal challenge was brought by the father of a 4 year old boy, named only as B, left permanently debilitated and with reduced life expectancy after two doctors at Chelsea and Westminster Hospital in London lost four crucial days in diagnosing and treating Kawasaki's disease.

In May 1994 an independent inquiry set up by North West Thames (now North Thames) Regional Health Authority found that the four days had been lost through deficient medical care. By January 1995 the authority had told the parents that the two doctors would face disciplinary proceedings.

The judge said that the parents were subsequently confronted with "either a lacuna or a breakdown in the continuity of responsibility for disciplinary action within the NHS." The doctors held dual appointments as medical school clinical lecturers and honorary senior registrars.

The regional health authority proposed to go ahead with the disciplinary proceedings, but a question arose about whether it had the power to do so after the reforms. The trust, believing it had no power to do so itself, asked the regional health authority to hold a disciplinary hearing as its agent, but the doctors' solicitors questioned this power as well.

Amid the uncertainty a compromise was reached with one doctor in February 1995. Disciplinary proceedings were withdrawn on condition that he accepted counselling about B's care and his clinical management generally, to be followed by a report and, if this was unsatisfactory, by further monitoring. In May the second doctor agreed that the incident should be taken into account on any future application for a clinical directorship; to accept monitoring and counselling; and to apologise to B's parents.

The judge said that the regional health authority had no standing in the matter of discipline as the trust had become the doctors' employer. The critical question was whether the doctors' honorary clinical contract with the trust from 1 April 1994 was a

new contractual relationship or a continuation of the earlier relationship with the regional health authority. The judge ruled that the doctors' employment by the trust was a continuation, and therefore it had disciplinary powers in this case. It had no power, however, to transfer its responsibility to the regional health authority as agent.

Mr Justice Sedley said that the right course would be for the trust to consider the independent inquiry panel's findings in the light of its true legal functions. What course it then decided to take was "a matter for its professional judgment alone." B's parents, while they could challenge a failure in starting the process, would have no standing to challenge the outcome. A spokeswoman for the trust said that the board would consider the ruling at a meeting on 25 January.

—CLARE DYER, *legal correspondent, BMJ*

Health secretary faces GPs to discuss primary care

Primary care in the NHS needs to provide a better service, provide a better place to work, and be better resourced, the health secretary, Mr Stephen Dorrell, said last week. Mr Dorrell was outlining his vision for the future of general practice at a meeting of the General Medical Services Committee (GMSC).

He told the committee: "I do recognise that there is a sense that general practice has become the sink where every other activity is unloaded that cannot find a home elsewhere within the health service." He went on to list the weaknesses of the existing structure of

general practice, saying that for him the key weakness was the gap between the best and the worst, which he said was simply too great. "We have to confine that variation within acceptable limits."

Mr Dorrell spoke of a clear role for developing primary health care as an important element of the emergency services. He added: "If we are talking about shifting work to general practice, that might mean general practitioners delivering more emergency care in hospital premises as well as surgeries. I am not saying that in future general practice will have a large element of hospital based practice. But where a general practitioner is interested, then I am interested."

But his accompanying assurance that "growth of service in primary care will be matched by growth of resources," was met with scepticism by the GMSC to the extent that during a discussion on morale among general practitioners Mr Dorrell countered: "Now you are making my morale low."

Committee members raised several concerns during the meeting with Mr Dorrell, notably on the problems associated with treating people with mental illness under the care in the community policy; recruitment difficulties; increased workloads; morale among general practitioners; and current problems in attracting and retaining women doctors.

On the subject of recruitment Mr Dorrell admitted that he had received reports of advertised posts for which no one had applied. He said: "Where you cannot recruit people on the conventional independent contractor model then part of the solution is probably to have salaried contractors."

Earlier this month Mr Dorrell announced that the government will review primary care services in Britain.—CLAUDIA COURT, *BMJ*

Patients try to save historic practice

Last week in the remote dales of Yorkshire 600 patients attended a public meeting to debate the future of Britain's most historic practice. They were patients from the Aysgarth practice, once run by Dr William Pickles, who immortalised it in his classic, slim volume, *Epidemiology of a Country Practice*. Now, with the current husband and wife incumbents retiring after 15 years, the local family health services authority has appointed Dr John Hamer to take over.

Dr Hamer runs the neighbouring practice at Hawes with his partner, Dr Duncan Roche, and plans to merge the two practices into one. It was this proposal that led to the public meeting, at which patients voiced fears that their historic practice would be no more; that they could be obliged to trek nine miles to Hawes outside surgery hours; and that in emergencies the doctors on call could take the better part of half a day to reach some of their patients.

The practice at Aysgarth was established in the village in 1886 and was joined in 1913 by Dr Pickles, who during his long career there became famous for his work in recording and publishing the details and incidence of infectious diseases in this remote region. His work brought him international fame and a second career lecturing all over the world. He was also a founder member of the Royal College of General Practitioners, where an annual lecture is given in his honour.

Dr Hamer admits that the prospect of taking over such a historic practice is "daunting." But he says: "One is aware that Pickles was a pioneer, and it would be tragic to lose this place where he practised, but in some ways this simply means that the Pickles practice is becoming bigger. We hope to appoint two principals, and the doctors will all live at Hawes, but we do not propose to close the Aysgarth surgery." The local MP Mr William Hague, who is also the Welsh secretary, is looking into the matter of the merger.—CLAUDIA COURT, *BMJ*

Ian Bogle, chairman of the GMSC, greets Stephen Dorrell (right)

Judge criticises transplant blunder

A High Court judge in Britain last week criticised a Sussex hospital where a cancerous kidney was transplanted into a patient for "blunders" that nearly cost the man his life. Peter Sumners, aged 51, claimed damages after he developed cancer from the kidney, which was transplanted at the Royal Sussex County Hospital, Brighton, in June 1986. Doctors discovered within days of the transplant that the donor had had cancer, but waited seven months before telling Mr Sumners.

Brighton NHS Health Care Trust admitted that Mr Sumners should have been warned earlier that the kidney was cancerous but contested the size of his claim for dam-

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ages. As we went to press, Mr Justice Collins was due to deliver judgment on damages.

Mr Sumners had months of radiotherapy and dialysis, then his disease mysteriously went into remission after he had believed for months that he was dying. He received a second transplant in June 1990.

The judge said that the hospital staff could not really have made greater blunders in the way that they treated him once they realised that they had put in a potentially cancerous kidney, even if they meant well.

A key issue is whether Mr Sumners should be compensated for future worry that his recovery may not be permanent. To arguments from the trust that he should not receive compensation for the anger he felt at his treatment, the judge countered: "Why shouldn't anger be something he should be compensated for?"

A woman in her 50s who received the donor's other kidney is also claiming damages from the trust and hopes to receive an out of court settlement. She did not develop cancer. The judge held that the hospital was not negligent in failing to diagnose the kidney as cancerous. A spokeswoman for the trust said that nowadays patients would be fully consulted at an early stage.—CLARE DYER, *legal correspondent, BMJ*

Scottish royal college tackles pre-hospital care

The Royal College of Surgeons of Edinburgh is setting up a faculty of pre-hospital care and is offering membership to non-medically qualified staff. The faculty will be the first of its kind in the United Kingdom.

Many different people may play a part in the management of patients from the time they fall ill to their arrival in hospital, and outcomes are thought to improve when these different activities are well coordinated.

Dr Brian Steggle, joint honorary secretary of the faculty said: "What we are trying to achieve is that the care continues without any gaps. It may sound obvious but that has not always happened in the past."

Membership of the faculty will be open to suitably qualified representatives of all the disciplines that play a part in pre-hospital care, including doctors, nurses, ambulance staff, and members of voluntary aid societies and rescue organisations.

The faculty will aim to set and maintain standards, improve education and training,

initiate research, and integrate the work of all the groups concerned.

While the individual disciplines will maintain their own training programmes, the faculty will provide an advisory and coordinating role. The establishment of the faculty was warmly welcomed by Simon Davies, who represents the Royal College of Nursing on the management committee.

"We have to know each other's roles and strengths. It comes down to education and training—you have to train together to know how to work together," he said.

The Royal College of Surgeons of Edinburgh has been active in pre-hospital care for many years. It developed a specialty fellowship examination in accident and emergency medicine and surgery 16 years ago and followed that up with a diploma in immediate medical care in the late 1980s.

The college president, Sir Robert Shields, said that the decision to open the faculty to non-medically qualified staff had won enthusiastic support from within the college.

"I think the medical profession is often blamed for being parochial, insular, and isolated," he said. "That is not the way medical care is going today—you have to have a team of people."—BRYAN CHRISTIE, *health correspondent, Scotsman*

Focus: Washington

Scientists' new year: from dismal to delightful

The new year has brought first bad news, then worse news, and finally very good news to the major medical agencies of the US government. As the Republican controlled congress

started slashing government spending to reach a balanced total budget by 2002, the National Institutes of Health (NIH) was warned to prepare for cuts of 5-10% a year over five years to its annual budget of almost \$12bn (£7800m). The rumours from those discussions reverberated through America's medical schools, whose research is supported primarily by the NIH.

But that bad news was only rumour. Reality came when the Congress and President Clinton failed in early January to reach a compromise over the federal budget, and the government was shut down for two weeks—including most of the NIH and the Centers for Disease Control and Prevention (CDC).

At the start of the shutdown the NIH already had a backlog of 4000 grants and contracts totalling about \$800m (£520m), which will not now be cleared for six to eight months.

Patients were still treated at the NIH campus in Bethesda, but no new patients were enrolled in trials. The NIH phones, which get over 5000 calls a day, were silent; 9300 of the NIH's 16 000 workers were told to stay at home; and the National Library of Medicine, which runs the giant Medline information service, stopped entering medical literature into its databases.

But perhaps the most immediate effect was felt from Atlanta, where the CDC was in the midst of its busiest season, tracking the year's influenza outbreak, when the shutdown came. The main agency was kept open, but many field workers around the country were laid off. And layoffs of "non-essential" support staff such as secretaries and custodians made the work of the laboratory scientists slow to a crawl.

As a result the CDC could not accurately track this year's influenza strain, A(H1N1), even though early reports in December suggested that death rates from it were running higher than usual.

But by last Tuesday the government was back to work, and scientists in Washington, Atlanta, and field offices were trying to catch up. And then came the good news. In contrast to the earlier predictions, the NIH now appears to be in favour with the penurious Republicans. Their strategy once had been to hand President Clinton an overall budget

cutting bill that he would have to either veto—and again close down the government—or accept. But Republicans now are slicing up the pie and sending Mr Clinton small bills that fund one or two agencies at a time.

As a result, instead of cuts, the NIH will get a 5.8% increase—about 3% over the rate of inflation and \$175m (£115m) more than Mr Clinton had requested. Certainly, the increase is less than the 14% annual increase the agency saw in the 1960s and the 9% of the 1970s and 1980s. But it is better than the 3-4% increases of the past five years.

When the Republicans took over Congress in 1992 they favoured moving biomedical research to the private sector. But to their surprise, the private sector has become one of the NIH's biggest supporters. Biomedical research firms say that very basic science that is supported by the government is a long term investment that private industry cannot replace.

According to one business leader, the NIH has provided "the seed money from which America's worldwide leadership in biotechnology has sprung." Such arguments apparently removed the NIH from the budget wars, and what began as a dismal year for the US research community now appears to be a very happy new year indeed.—JOHN ROBERTS, *North American editor, BMJ*