it could be considered an assault. The working party has recommended legislation to circumvent this legal impediment.

The report states that "in most countries of the European Community, seriously ill, comatose patients are routinely admitted to an intensive care unit while undergoing investigation, often while ventilated. In such circumstances interventional ventilation is not necessary." To many outside Britain, the idea that seriously ill, comatose patients are not routinely admitted to an intensive care unit seems extraordinary. The authors of the report point out that in Britain, reimbursement for costs at the donor intensive care unit is £1000, compared with as much as £40 000 in Spain. One can but speculate how a much higher level of reimbursement might change the mindset of those currently charged with managing intensive care units in Britain.

The Spanish system of organ procurement comes in for special comment. Despite a dramatic decrease in fatal road traffic accidents,⁴ organ donation rates in Spain reached 27 per million population in 1995, in contrast with 15.8 per million in Britain. Spain itself attributes this success to its transplant coordination network, which has a different philosophy from that in Britain. In Britain, transplant coordinators are based in renal transplant centres, while in Spain they are based at the site of organ donation. The prime function of the Spanish local donation team is to detect potential organ donors within intensive care units at an early stage and to monitor the medical progress through to a diagnosis of brain death and subsequent organ donation. The success of this policy is evident from the donation rates achieved. Whether or not such a system might be adopted in Britain, the report highlights the inadequacy of Britain's current transplant coordinator network and emphasises that a major expansion of coordination is "one of the most important and urgent needs."

The working party highlights the urgent need for improved funding, not only to increase intensive care facilities and improve coordination networks but also to increase surgical staffing and provide teams qualified to undertake asystolic donation. However, the report fails to address those measures that could be undertaken within existing budgets to maximise the country's current donation potential. Measurable increases in organs have been achieved in other countries by introducing mechanisms for donor detection, staff education, and donor maintenance.^{4,5} Our own experience with the European Donor Hospital Education Programme in over 30 countries

around the world has shown that simple education policies on requesting organ donation can considerably improve organ donation rates.⁶ Data presented to the British Transplantation Society on a controlled evaluation of the programme in the north west region of Britain confirm this positive effect (RA Sells, personal communication).

A multinational effort to address all areas of the donation process is now being piloted in selected hospitals throughout the world. This programme, called Donor Action, seeks to introduce the best practices from around the world for the benefit of staff who may be involved in treating potential organ donors and patients on transplant waiting lists. It provides a comprehensive package of tools, resources, guidelines, and training to help a donating hospital diagnose its own potential for organ donation and improve its own donation practices. After a diagnostic review, areas of weakness can be identified and the appropriate management and educational changes introduced.

The working party's report highlights the desperate need for increased funding to improve rates of organ donation in Britain. Its recommendations are to be warmly welcomed. However, the transplant community should also consider whether practices existing elsewhere in Europe could help to improve the supply of organs for transplant within the budgetary constraints of the NHS. Unfortunately such considerations were outside the remit of this report.

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Landmines: time for an international ban

The United Nations must end this indiscriminate killing and maiming of civilians

Anti-personnel landmines remain one of the unmet challenges of preventive medicine. In the aftermath of modern civil and international conflict, civilians—especially children—continue to be killed long after the end of hostilities.^{1,2} Many victims are not recorded in official statistics. None the less, estimates place the current death rate at some 800 people a month, with another 1000-2000 surviving each month with blast injuries and consequent disability.¹ At least 26 of the estimated 200 nations of the world have landmines seeded over their surface, and many other countries have a role in their manufacture, sale, and use. Even if an international moratorium on the manufacture and use of anti-personnel mines were achieved now, landmine clearance will take centuries.³

The case against the continued production and use of anti-personnel mines, like that against poison gas and biological warfare, is their indiscriminate effects on civilians and children. The profession of arms, like all professions, has evolved a code of ethics,⁴ with the underlying ethos that even

when all attempts to maintain peace have failed, when peoples or nations go to war, it is still possible to prosecute combat at a level above that of animalistic degradation.⁵ All nations currently regard the use of landmines as legitimate weapons of war. If used within existing ethical codes (laying, isolating with barbed wire, marking conspicuously, mapping, and lifting after deployment) there is no moral violation in their tactical use. But, as with poison gas and biological weapons, those most likely to use them are those least likely to observe humanitarian codes of armed conflict.

Landmines are specifically designed as anti-vehicle mines, as ambush weapons, or as anti-personnel mines. Modern anti-vehicle mines are highly sophisticated and contain computerised circuitry that can detect critical mass, ferrous metals, or vibration, and can select vehicles or other hard targets for destruction. There are now a bewildering array of anti-personnel mines, and more than 60 different types are used in conflict zones.⁶ Anti-personnel mines can be

improvised, often with great ingenuity, from simple explosives with crafty triggers, such as those made from slit bamboo and nails or metal foil. In the past decade, however, mass production of anti-personnel mines has lowered the unit price to only a few pounds sterling, and even the poorest nations or groups of insurgents can import tens of thousands each year. Over 110 million landmines are currently in existence.^{1 6}

Anti-personnel mines require only a small charge of explosive to be effective. To fulfil their tactical role—that of immobilising and denying ground to an enemy—the blast need be sufficient only to avulse limbs. With deadly cynicism, many armies use smaller mines to wound rather than kill. A dead soldier will not in himself halt an advance, but an injured one requiring resuscitation and rescue will.⁷ Formal tactical training in many countries acknowledges that extracting survivors of landmine blasts (some 40-50% of victims survive) hinders morale, ties up transport and other resources, and demands aeromedical evacuation.

Although anti-personnel landmines may be a legitimate weapon of war, they have no place in an ensuing peace.⁵ The civilian death toll shows that they are often sown in places where civilians—especially children and farmers—work, forage, and play. Many of the anti-personnel mines used in the 1990s were made entirely of plastic to escape detection and so may float in floodwater run off, killing and injuring people many kilometres from the site of primary implantation in places where mines are not considered a threat. This has been a particular problem in Afghanistan,⁸ Cambodia,⁹ and Rwanda,⁵ where all plastic, butterfly shaped, “babykiller” mines have been dispersed by air.

The medical consequences of landmines are well known. Avulsion of one or both feet or lower limbs is typical,⁵ with shrapnel fragmentation wounds to the pelvis, abdomen,⁵ thorax, and face. Blinding in one or both eyes is common,¹⁰ and conductive deafness almost inevitable.¹¹ The blast wave travels up the bones of the leg,⁸ and amputation well above the site of frank avulsion is necessary because of bony as well as soft tissue devitalisation.⁸ Civilian injuries usually involve more than one victim, and sometimes whole families or groups of children are killed or injured.^{1 5} The legacy of legless, partly deaf, blinded orphan children is a challenge for preventive medicine that the medical profession cannot ignore.

At the international level much has been achieved in drawing up a code of combat. The St Petersburg Declaration (1868), the Brussels Conference on the Rules of Military Warfare (1874), the Hague Conventions (1899 and 1907), the

Washington Treaty (1922), the Geneva Conventions (especially the 1949 codifications),¹² and the Resolutions of the International Committee of the Red Cross (especially those of 1965 and 1977)¹³ have followed the evolution of technology, banning in turn the inhumane use of dum-dum bullets and poison gas,^{14 15} the torture of prisoners—military and civilian—caught in combat zones, and the use of offensive biological weapons.

The common thread woven through this ethical evolution of the profession of arms is that all such weapons are indiscriminate in their effects. The technology of the 20th century has produced a cheap, highly efficient, indiscriminate killer. In this context it is logical, indeed now mandatory, to insist on a new international convention to ban the manufacture, trade, and use of anti-personnel mines. Last October, in Vienna, the United Nations failed to agree to ban landmines. In January it failed to agree on the feasibility of a lesser target of forcing manufacturers to install fuses that would inactivate landmines within six months. This week at the United Nations convention on inhumane weapons, the international community has a third opportunity to act. It must not fail.

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The continuing rise in emergency admissions

Explanations and responses must be properly evaluated

Emergency admissions in Britain are continuing to rise.¹ The highly publicised bed crisis this winter and a number of national meetings have underlined concern over the lack of explanations and frustration at the lack of control. In Scotland, emergency admissions increased by 45% between 1981 and 1994 (fig 1). This represented an annual increase of about 3%, rising to over 5% in 1993 and 1994,² and probably in 1995. Even steeper increases have been reported by individual hospitals throughout Britain.^{1 2} In stark contrast, elective admissions have increased by only 1% a year.³ Emergency hospital admissions account for about 40% of total acute bed use in the NHS.²

Why is this rise occurring? Potential explanations need to account for its generality and persistence. Hospital admissions have actually been increasing for some four decades.^{1 3} Some

recent inflation in the figures was caused by the use of finished consultant episodes and more complete recording. However, analysis of linked data has confirmed that the rise is genuine.² Only 2% of the increase can be explained by population aging.^{1 2} Although all age groups and diagnostic categories are involved in the rise, major contributions come from older medical and surgical patients, multiple admissions, and socially deprived groups.⁴ In Scotland, admission rates have always been higher in health board areas with teaching hospitals but the rise has generally been steeper in non-teaching health boards, so that the gap is now narrowing. Decreasing length of hospital stay increases the risk of premature discharge, leading to “revolving door” readmission.¹ The detection of additional disease by more sensitive investigations may also contribute.⁵ However, with the exception of