French biscuit makers force tobacco campaign ban

Legal action by French biscuit manufacturers has succeeded in halting publication of an advertisement which claims that eating a biscuit a day is a greater cardiovascular risk than breathing secondhand tobacco. The biscuit manufacturers took their case to the highest civil court, the Paris tribunal de grande instance, where Jean-Pierre Marcus, vice president of the tribunal, promptly ruled against Philip Morris Europe.

Philip Morris launched a European advertising campaign early in June in which it compared the risk of passive smoking to that of eating biscuits, drinking milk or chlorinated water, using too much pepper, or frying food with rapeseed oil.

The judge ruled that the campaign represented advertising in favour of tobacco, in violation of French legislation. In addition, said the judge, such advertising is detrimental to the interests of biscuit manufacturers, whose products are said to be more harmful than the effects of passive smoking. The judge ordered Philip Morris to call a halt to the campaign, ruling that the company would be fined Fr1m (£125 000, \$187 500) for each advertisement appearing after the court order. Philip Morris has filed an appeal against the ban.

The National Anti-Tobacco Committee is also suing Philip Morris, asking for damages equivalent to the cost of the advertising campaign, Fr6.5m. The committee is an independently run organisation that receives subsidies from the Ministry of Health. It regularly monitors tobacco advertising in France, where legislation is strict but not always strictly enforced.

Professor Louis Hirsch, a chest physician at the Saint Louis Hospital in Paris, said that the harmful effects of passive smoking are no longer a matter of scientific controversy but that tobacco producers are ready to fight tooth and nail not to lose ground.

"Imagine authorities enforcing the ban on smoking in public. It would lead to a significant drop in consumption, if only because it would help a certain number of smokers to stop smoking. It [Philip Morris] fears an evolution of behaviour in developed countries."

A spokesman for Philip Morris said the advertising campaign had successfully made the point that too often a scientific study is poorly interpreted to exaggerate risks. The campaign was now coming to an end across Europe as scheduled but this was nothing to do with the court case, he said.—ALEXANDER DOROZYNSKI, medical journalist, Paris

Eating a biscuit is more risky than passive smoking, claims tobacco manufacturer

Labour pledges to cut NHS bureaucracy

The Labour party pledged this week to cut £100m (\$150m) from bureaucracy by ending the system of extracontractual referrals and reducing management costs in all health authorities and NHS trusts to at least the current average. The immediate result would be 100 000 patients taken off waiting lists, says the *Road to the Manifesto*, a briefing document which is due to be endorsed by the party in the autumn.

Shadow health secretary Harriet Harman, who prepared the report, said that it marked the beginning of Labour's renewed focus on patient care and a new lease of life for the NHS. "Swift emergency treatment and a cut in waiting times are what people want," she said.

General practitioners would experience greater freedom of referral under a Labour government, the document claims. The present 12 week "paper chase" of extracontractual referral would be replaced with a one step system in which the doctor makes an immediate telephone appointment with the hospital and gives the patient an appointment card.

The Labour party declared that the NHS

would be one of the key dividing lines between it and the Conservative party at the next general election in Britain. "The future of the NHS under the Tories is clear," the document states. "If the Tories are elected again, they will strip the NHS down to the basic emergency services. For everything else, people will have to pay."

As evidence, Ms Harman cited the two million fewer people on NHS dentists' lists; one in five non-urgent operations in England now being done in the private sector; and the growth of private long term care for elderly people. As patients are forced into the private sector, public commitment to the NHS is weakened, the document states.

Health secretary Stephen Dorrell dismissed Labour's plan as a mirage. He said it was easy for an opposition party to promise wonderful things by simply making the administration more efficient.

Commenting on the document, BMA council chairman Dr Sandy Macara said: "I welcome the recognition of the potential to release resources for direct patient care by cutting out the disastrous costs of the ill fated, so called internal market." But he said he was worried there was no specific commitment to ensure released resources are used effectively and focused on clinical priorities.—JOHN WARDEN, parliamentary correspondent, BMJ

Headlines

Australia's euthanasia law may fail: The world's first voluntary euthanasia law, which came into force in Australia's Northern Territory this week, seems doomed to failure. Leaders of the three main political parties oppose the ruling; a bill will be introduced in the federal parliament in September to strip the state of its power to allow euthanasia, and the law will be challenged in the Northern Territory supreme court.

NHS Executive and BMA collaborate on confidentiality: The NHS Executive is to set up a working party with the BMA to review all uses of patient information outside direct care and research. This will address the BMA's concerns about confidentiality issues, such as contract datasets and item of service claims.

British patient sues because he did not die: Mr Cyril Smith, who was told in 1992 that he had cancer and only months to live, has been granted legal aid to sue doctors because he did not die, claiming loss of earnings and unnecessary mental anguish.

Chinese birth control rule extended: Chinese women who live in Shenzhen on the border between China and Hong Kong must abide by the "one child" policy even if they are married to Hong Kong men and their first child has moved to the British colony. They will be forced to undergo an abortion if less than seven months pregnant.

Cot deaths come down in US: The death rate from the sudden infant death syndrome fell in the United States by 30% between 1993 and 1995, the government reported last week. One reason is a campaign which encouraged parents to place sleeping babies on their backs.

More people now detained under Mental Health Act: Between 1989-90 and 1994-5 the number of formal admissions to all facilities under England's Mental Health Act rose by 55% from 17 400 to 27 100.

League tables for primary care: Three quarters of general practices in England have a practice charter, according to the first NHS performance tables to cover primary care. Nationally 95% of children have received a course of immunisations for diphtheria and 91% for measles, mumps, and rubella.

BMA opposes NHS private finance initiative

The BMA has come out firmly against the private finance initiative (PFI) in health care but has recognised its inevitability. At its annual representative meeting in Brighton last week, members referred to the scheme as the death knell of the NHS but accepted that there was often no alternative source of funding for new hospitals or departments.

The scheme was introduced in 1992 to encourage private companies to fund or manage projects that would previously have been run by the public sector. Since 1993 trusts and health authorities have been expected to consider private sector alternatives in capital projects.

Speaking at the meeting, Dr Stephen Watkins, chairman of the BMA's public health committee, said: "We must say that we are not prepared to hand NHS money over to the private sector at exorbitant interest."

According to Dr John Marks, former chairman of council, PFI was a continuation of the covert privatisation of the NHS, which started with eye tests, continued through dentistry and the care of elderly people, and was now facing the core of the service. Yet not one single, major PFI contract had been signed, and the reason was clear: "No commercial organisation puts money into a project unless it has a chance of repayment."

Although sharing these reservations, Dr Thomas Hawkins, a consultant anaesthetist in Nottingham, gave an example of where PFI could work. The ear, nose, and throat surgeons in his hospital were forced down the PFI road because the local purchasers did not want to pay for extra facilities.

The doctors were determined that their clinical freedom would be maintained and

that their contracts would continue to be held by the trust and not the financier. "We are undergoing a cultural revolution in the health service," Dr Hawkins said, "but we must work to make it work for ourselves."

The meeting recognised the potential offered by private involvement but said that it should not cut across the fundamental principles of "a comprehensive, high quality national health service free to all at the point of access." The BMA insisted on five further requirements: PFI should be limited to capital investments in buildings; the views and needs of doctors should be taken fully into account in developing facilities under PFI; all attempts to privatise clinical services should be resisted; PFI should not be allowed to stifle education and research; and adequate accommodation and mess facilities for junior hospital staff should be included in hospitals funded by PFI.

Supporting another motion that criticised PFI for causing delays in projects subject to capital funding, Dr Sandy Macara, chairman of the BMA council, pointed out that the scheme had not led to an overall increase in investment as the government had intended.

Government expenditure on capital projects had declined from £1.8bn (\$2.7bn) in 1995 to £1.6bn in 1996 and was expected to fall to £1.5bn and £1.4bn in 1997 and 1998 respectively. This fall was supposed to be offset by increased investment in PFI. But this had gone up from only £47m in 1995 to £165m in 1996 and was expected to increase to £200m and £300m in 1997 and 1998.

The NHS Trust Federation criticised the BMA for wanting to have its cake and eat it and for behaving like King Canute: "One minute it is making unrealistic, quite unrealistic demands of the government...the next day it is turning against one realistic measure which could bring many millions of pounds of private sector cash into the NHS to build and develop new hospitals."—LINDA BEECHAM, *BMJ*

BMA stress counselling service

(analysis of nearly 800 calls made between 9 April launch and 21 June)

The BMA's pilot telephone counselling service received nearly 800 calls in the first three months. Of these, 254 were concerned with emotional stress and anxiety, 222 with employment problems (mainly workload), and 82 with marital problems. The one year scheme was launched in April and is run by CareAssist.

WHO warns that multidrug resistant TB will spread

Careless administration of routine treatment for tuberculosis in South Africa has produced the world's highest incidence of drug resistant forms of the disease, the World Health Organisation has warned. And this misuse of drugs could speed up the spread of tuberculosis resistant to multiple drugs to the rest of Africa and the developed world.

A survey of the tuberculosis epidemic in South Africa conducted during 10-21 June found that almost two thirds of clinics issuing drugs to treat tuberculosis did not monitor their application, putting patients who failed to complete the prescribed course of treatment at risk of developing drug resistant strains.

"This is the most frightening situation I have ever encountered. If we do not act now we will have a situation that we cannot control," warned Dr Donald Enarson, a director of the Paris based international union against tuberculosis and lung disease. The problem is compounded by the HIV epidemic in Africa as tuberculosis spreads more quickly among immunocompromised people, he said.

About 4% of the 140 000 new cases of tuberculosis identified in South Africa last year were multidrug resistant. The WHO estimates there are 9.2 million cases of tuberculosis in sub-Saharan Africa, but resistant strains are largely confined to South Africa, where treatment is more widely available.

The combination of HIV and tuberculosis epidemics with a relatively well developed medical infrastructure is unique to South Africa. Consequently, the risk of multidrug resistant tuberculosis reaching epidemic levels is greater than in other areas such as New York, London, Milan, India, Thailand, Estonia, and Pakistan, where resistant strains have also been identified.

Last year tuberculosis accounted for more than 80% of recorded communicable disease in South Africa. If current trends continue, the level of infection will double from its current 1.7 million cases to 3.5 million within 10 years. The rate of HIV infection is increasing by more than 60% annually, rising fastest among migrant workers moving between neighbouring sub-Saharan countries. About 1.8 million South Africans (4.3% of the population) are infected with HIV, compared with 1.1 million a year ago.

Dr Olive Shisana, director general of South Africa's department of health, which wrote the report jointly with the WHO, said that tuberculosis had become "a disease more terrifying than AIDS or the Ebola virus." Worldwide, it is the principal cause of death among all adults and the leading killer of people with HIV.

The WHO urged South Africa to adopt the DOTS strategy (Directly Observed Treatment Short course), which requires health workers to monitor patients as they take their medication.—MARK ASHURST, *Financial Times correspondent, Johannesburg*

Villagers are forced to use contaminated water for cooking and drinking

SEAN SPRAGUE/PANOS PICTURES

Arsenic poisons 220 000 in India

At least 220 000 inhabitants of India's West Bengal state have symptoms of arsenic poisoning, in what is being called the "biggest arsenic calamity in the world." A report on arsenic toxicity resulting from groundwater contamination says that the number of people affected in the eastern Indian state is much higher than previously estimated.

The report (*Current Science* 1996;70:976-86), based on an eight year survey of the region, says that over one million people in 560 villages are consuming groundwater contaminated with high concentrations of arsenic that has leached out of the ground.

"This is just a tip of the iceberg—the real situation is probably much worse," says Dipankar Chakraborti, principal investigator of the survey and director of environmental sciences at Jadavpur University in Calcutta, the state's capital.

The survey so far has covered more than 26 000 groundwater wells and detected concentrations of arsenic ranging from five to 370 times the maximum permissible limit of 0.01 mg/l. A lack of other sources of water forces residents in the region to use groundwater for drinking and cooking.

Health problems in the population range from melanosis, spotted keratosis, and solid oedema of the feet to more severe complications such as hepatomegaly, splenomegaly, squamous cell carcinoma, and intraepidermal carcinoma. Cancers of the bladder, genitourinary tract, and lungs among residents may also be due to long term exposure to water with a high concentration of arsenic, researchers believe.

The symptoms of arsenic toxicity develop insidiously, taking six months to two years or even longer to appear, and depend on the

intake and concentrations of arsenic in the contaminated groundwater. The combination of melanosis and spotted palmar keratosis points to arsenic poisoning and excludes other cases of isolated pigmentation and nodular rough skin, says the report.

The survey has also shown high concentrations of arsenic in body tissues of patients with no apparent symptoms of arsenic poisoning. The average concentration of arsenic in hair and nails, for example, is between eight and 15 times the normal level, with concentrations hundreds of times higher in some individuals.

Groundwater contamination with arsenic has also been reported from Argentina, Chile, Mexico, Taiwan, Thailand, and the United States, but the number of people exposed at a single site has not exceeded 200 000. Chakraborti says that the problem in West Bengal holds a lesson for the world that any region where groundwater extraction goes unchecked "leaves itself open to a similar calamity."—GANAPATI MUDUR, *science writer, New Delhi*

Court rules that care cannot be withdrawn due to cash cuts

Local authorities in England and Wales have been plunged into uncertainty by an Appeal Court decision last week that councils cannot withdraw community care services from elderly and disabled people because of cash shortages. The landmark ruling by a two to one majority overturns a High Court decision that it would be "impractical and unrealistic" to stop councils making cuts if their budgets were reduced.

Gloucestershire County Council is appealing to the House of Lords over the decision. Unless reversed, the ruling means that, once a person has been assessed as having a need, it must be catered for regardless of resources. It will affect all local authorities in England and Wales and a wide range of services, including ironing, cleaning, and the provision of meals or housekeepers.

Gloucestershire County Council, which had argued that it had the right to withdraw home care services from Michael Barry, an 80 year old heart attack victim, said it was "seriously concerned" about the ruling and would appeal to the House of Lords. Stephen Thorpe, acting director of social services, said: "This decision will not only cause confusion and uncertainty within Gloucestershire but will also undermine social services across the country. It goes directly against the advice given to us by the Department of Health that we have been following." The department said that it would have to study the judgment before deciding whether to issue further advice.

Stephen Cragg, solicitor for the Public Law Project, which brought the case, said: "This is a wonderful victory for all those disabled people in receipt of services under the 1970 Chronically Sick and Disabled Persons Act. Those services are now guaranteed and cannot be removed or reduced whatever happens to a council's resources unless the person's needs change." Gloucestershire County Court withdrew services to 1500 disabled residents after cuts of £3m (\$4.5) in government funding in December 1993.

Mr Barry had enjoyed home care services including help with cleaning, laundry, and shopping and the provision of community meals. In September 1994 the county council withdrew his cleaning services and reduced his laundry provision because of shortage of funds. In a linked case the judges unanimously held that Lancashire County Council was acting lawfully in withdrawing care in the home from stroke victim Annie Ingham, aged 88. Her needs had been assessed as "24 hour care," and the judges held that the council was entitled to provide the care in a nursing home instead of her own home.—CLARE DYER, *legal correspondent, BMJ*

Ombudsman highlights confusion over long term care

The health service ombudsman, Sir William Reid, has criticised English health authorities for failing to have clear written criteria about eligibility for long term care and for poor arrangements for discharge from hospital.

In his second special report on the provision of long term care in nursing homes or hospitals for severely disabled patients, Sir William found that guidance on discharge is often ignored. Disputes arise because NHS care is free but private nursing home care is generally not. Although patients being discharged to private nursing home should be

told in writing whether the NHS would pay the fees, the report says this often does not occur.

The ombudsman's first report, in 1994 about a case in Leeds, was followed by new guidance from the Department of Health requiring health authorities to draw up eligibility criteria for continuing care, with independent panels to review contested decisions. Sir William says that it is too soon to say whether the department's new measures will be effective in increasing public confidence in the equity of decisions about continuing care.

A national review of eligibility criteria is to be completed by October 1996. Health authorities are to review their criteria by April 1997.—JOHN WARDEN, *parliamentary correspondent, BMJ*

Investigations of Complaints about Long Term NHS Care is available from HMSO, price £9.85.

Company challenges melatonin sales ban

A pharmaceutical company that makes melatonin—hailed by the United States media as a miracle "anti-aging" product—is to challenge the Medicines Control Agency's ban on over the counter sales in Britain.

Pharma-Nord, based in Morpeth, Northumberland, will seek leave this month for a High Court judicial review of the ban. The agency claims that the product, which is made from soya beans, has medicinal proper-

ties and should not be sold without a licence.

Millions of Americans take melatonin, a hormone produced by the pineal gland in the brain, as a remedy for insomnia and jet lag. In the US it continues to be classified as a health supplement, not a drug, and bottles are sold with a warning from the Food and Drugs Administration that those taking it do so "without any assurance that it is safe or that it will have a beneficial effect."

Melatonin, which can be prescribed in Britain only on a named patient basis, has continued to be widely sold over the counter despite the ban last October. A helpline was set up to advise members of the public where they could buy it. The England football team used it to combat jet lag on its recent tour of the Far East, though the team insists that it was obtained on prescription.

The control agency, which has power to bring prosecutions and to clear shelves of banned products, had ordered all outlets to remove melatonin from their shelves by 28 June. But the agency has told Pharma-Nord that it will not seize stock or prosecute pending the outcome of the court case, according to the company's managing director, Bent Henriksen.

Mr Henriksen, whose company manufactures melatonin in Denmark, said that it was being sold as an antioxidant. "Twenty million Americans have been taking it for 10 or 15 years. The Food and Drugs Administration would have jumped on it long ago if one person had got ill." But Jo Arendt, professor of endocrinology at Surrey University, pointed out in a recent *BMJ* editorial (18 May, pp 1242-3) that no data exist on long term studies in humans.—CLARE DYER, *legal correspondent, BMJ*

Guidance on hospital discharge procedures is often ignored

JOHN COLE/IMPACT

US doctors reaffirm opposition to euthanasia

In the face of growing public and legal support for doctor assisted suicide, the American Medical Association has reaffirmed its adamant opposition to the practice.

The association's 430 member house of delegates gave a near unanimous vote against euthanasia during its annual meeting in Chicago last week. Members representing the various state and specialty medical societies stated that doctors should be healers and not killers.

The association also said it would work to develop programmes to "facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life." Doctors in the US are reluctant to prescribe the large quantities of drugs needed to relieve the pain of dying patients that are routinely prescribed in Great Britain and some other countries.

Those against doctor assisted suicide spoke of the potential damage to the profession and the inability to control the practice once the "genie is out of the bottle." After the debate Dr Nancy W Dickey, chair of the association's board, issued a statement saying, "The medical profession will not tolerate being put in a position to judge the value of the lives of the patients we are trained to heal, comfort, and care for. Individuals have every right to control their own destiny. This does not mean, however, that they have a right to have their physician, their trusted ally in health, help them to die."

She said that physicians "must be armed with the knowledge and the know-how to compassionately control pain, encourage and preserve patient autonomy, and identify those individuals considering suicide and get the help they so desperately need and are silently requesting. When faced with death, we must realise that our lives have value and dignity, regardless of our physical state."

Only one doctor opposed the association's policy. Dr Ulrich Danckers urged the association to "assume a neutral position until public discussion and the judicial and legislative processes have determined where this nation will position itself on this issue."

Doctors should not substitute their judgment for that of their patients, he argued: "It is intellectually dishonest for us to collectively get on our high moral horse by declaring the practice unethical and then look the other way when our members in ever larger numbers quietly endorse the practice at the bedside."

Thirty four states have laws explicitly forbidding doctor assisted suicide, and the common law ban is recognised in 10 other states. However, the status of these laws is in limbo after federal appeals courts have decided that states cannot prohibit doctor assisted suicide. The legal matter must ultimately be resolved by the US Supreme Court. —CHARLES-GENE MCDANIEL, *medical journalist, Chicago*

Wide variations in NHS Supplies Authority's prices for cornflakes and thermometers

NHS pays too much for some supplies

Britain's public spending watchdog, the National Audit Office, has found wide variations in the prices paid by different divisions of the NHS for goods. It concludes that the NHS Supplies Authority could make substantial savings on the £2bn (\$3bn) of goods and services bought annually by the health service.

The report notes that "there were wide variations in the prices NHS Supplies charged to their customers for particular goods and these sometimes resulted in customers paying well above or below the actual cost."

For example, the price of cornflakes varied from 74p to 96p a box (a difference of 29%), and clinical thermometers ranged from £3.80 to £5.61 (a difference of 48%). The National Audit Office says that a new costing system currently being introduced should help the NHS Supplies Authority to improve this situation.

The report concludes that, overall, prices for a basket of goods from the supplies authority compare favourably with those achieved by other organisations purchasing healthcare supplies. The National Audit Office suggests that "a systematic analysis of price differences would target scope for further savings, and savings are also achievable in administration and by helping to reduce suppliers' costs."

The report also looked at customer satisfaction. It found that 37% of trusts' chief executives surveyed were dissatisfied with the arrangements for negotiating annual service agreements with the NHS Supplies Authority, and 35% were not satisfied that these

arrangements provided value for money.

The NHS Supplies Authority operates in competition with other commercial suppliers and in 1994-5 bought goods worth around £470m, which it sold on to NHS customers. These included 43 million pairs of examination gloves, 300 million needles and syringes, and 180 million tea bags.

The National Association of Health Authorities and Trusts responded to the report by emphasising what it called a "partnership approach" to major suppliers. The association's deputy director, Jean Trainer, said: "Rather than shadow boxing it would be much better if the NHS could establish long term relationships with suppliers, building quality requirements into contracts." —CLAUDIA COURT, *BMJ*

US Scientific Fraud Office found at fault

The United States Office of Research Integrity has been portrayed as a kangaroo court and found at fault over a case of scientific fraud involving one of America's most well known medical scientists, Dr David Baltimore.

Dr David Baltimore, a Nobel laureate, resigned in 1992 as president of Rockefeller University after one of his junior scientists, Dr Theresa Imanishi-Kari, was accused of fraudulently reporting data from an immunology study of mice that was published in the journal *Cell* in 1986. Dr Baltimore was a coauthor of the paper.

The National Institutes of Health's policing division, the Office of Research Integrity,

took up the case after a powerful congressman, John Dingell of Michigan, said this showed how the scientific community could not police itself. In 1991 the fraud office accused Dr Imanishi-Kari of inventing data and she was barred from receiving further government grant money.

But a three person appeal panel last week said that it was the ORI, not Drs Imanishi-Kari or Baltimore, which was at fault. The panel said that it had not come close to proving its case, and, even though it produced huge amounts of data in support of its prosecution, "much of what the ORI presented was irrelevant." The panel was made up of two officials from the Department of Health and Human Services and a retired professor from the University of Pittsburgh.—JOHN ROBERTS, *North American editor, BMJ*

Guernsey bans tobacco advertising

Guernsey has become the first place in the British Isles to impose a complete ban on tobacco advertising as part of a widespread package of antismoking measures aimed particularly at teenage smokers. Guernsey's board of health initiated, researched, and

finalised the measures, which were accepted by Guernsey's parliament last week and will take effect from January 1997.

Dr David Jeffs, the island's director of public health, said, "It has taken determination against considerable, orchestrated, and well organised opposition, but both bodies have stuck to their guns. Given the considerable benefits to public health, we hope the UK will have the courage to rapidly adopt similar measures."

Unlike in the United Kingdom, where a packet of cigarettes costs £2.75-2.80 (\$4.12-4.20) a packet, a similar brand costs £1.76 in Guernsey because of low duty. From next January 45p in extra duty will be added, and there will be an annual rise of 8.5% on duty for the next five years.

Other measures include the banning of cigarette advertising on hoardings or in local newspapers and sponsorship of sports events by tobacco companies. Legislators will not be able to prevent the publication of tobacco advertising in national magazines and newspapers arriving from the United Kingdom. The minimum age for buying tobacco will increase from 16 to 18. Pamela Furness, chief executive of Action on Smoking and Health, called Guernsey's action the "most important precedent in tobacco control in the Western world in recent years."—ALISON BOULTON, *freelance journalist, London*

French asbestos victims go to court

A French association representing people with asbestosis has filed a lawsuit charging "X" with poisoning, involuntary homicide, criminal negligence, and wilful fraud regarding the risk of a product. Although X designates a person or persons unknown, the 86 page brief retraces the history of the use of asbestos, naming industries, citing the permanent asbestos committee as its major lobby, and charging public health officials with ignoring a known risk.

Founded last February, the association, called Andeva, paved the way for coordinated action by thousands of people affected by asbestosis, sometimes with secondary heart disease and lung cancer. France banned asbestos spraying in 1977—the last of seven western European countries to do so.

The number of deaths related to asbestos has reached about 3000 annually and continues to rise. According to some estimates, it may peak at about 10 000 deaths annually in 2010.

A statement from Andeva says: "Civil servants in charge of public health should not have ignored the multiple breaches related to the use of asbestos."—ALEXANDER DOROZYNSKI, *medical journalist, Paris*

Focus: Sydney

Disaster plans and prevention

The Sunday afternoon murder in April of 35 people and the wounding of another 18 by a lone gunman at

Tasmania's Port Arthur tourist site unleashed a programme of unprecedented gun law reform in Australia. If prime minister John Howard and the eight state and territory police ministers have their way, within a few months all parliaments will have legislated for uniform national gun laws. These represent the local gun lobby's worst nightmare: linked licensing of the person who wants to shoot and the registration of his or her guns; a ban on all semiautomatic rifles and pump action shotguns; the end of private owner-to-owner gun sales; and tougher definitions and documentation procedures for both "reason" and "need" to own a gun. All prohibited guns will be bought and destroyed by the government with money obtained from a small rise in the compulsory Medicare levy on wage earners.

Howard has never enjoyed a reputation as a political tough guy, but his swift actions to stop Australia travelling any further down

the American road of gun violence have earned him respect. Polls show that over 90% of the public support gun law reform.

However, 'tis many a slip twixt cup and lip. An incensed gun lobby has been drawing rallies of up to 70 000 shooters—99% of them men—who are going ballistic over the implication that they are somehow to blame for Port Arthur and for Australia's annual average of 620 deaths caused by guns. An axis of anti-immigration, industry protectionist, and pro-gun interests has formed a new party, predictably called "Australia First."

The gun lobby regularly boasts about the way it has derailed gun law reform in Australia. Part of the gun lobby's proud record of "success" was to keep the Tasmanian government from changing the very laws that allowed the Tasmanian gunman access to the military assault weapon he used. The gun lobby protests that its law abiding members are being "blamed" for Port Arthur. But in view of its boasts before Port Arthur, is there any other word for it?

As countless letter writers to the media have pointed out since the massacre, living in a community carries with it impositions on law abiding citizens that are designed to safeguard the whole community. Many who

attend pro-gun rallies feel insulted at the implication that they might one day be a danger to the community. This is rather like feeling insulted at having to walk through a metal detector at an airport or at being pulled over for random breath testing.

Disaster plans are standard chapters in hospital procedure manuals. One of the big lessons from Port Arthur and its aftermath will be what public health groups can learn from such disasters: how they can translate outrage over public health catastrophes into a programme of advocacy designed to transpire the outrage into policy reform.

Australia and New Zealand have had 14 mass killings in the past decade. Port Arthur is the first that has led to major law reform. Without doubt, the leadership of the prime minister has been indispensable to the latest reforms. But his resolve has been made more politically palatable by the sustained interest of the media. In nine weeks the story has not left the top five news stories. Gun control activists have taken advantage of this to advance their proposals and derail the gun lobby's efforts to frame the new laws as unreasonable. Public health disaster plans should become as mandatory as their emergency medicine counterparts.—SIMON CHAPMAN, *associate professor of public health,*