HIV positive surgeon allowed to operate

A surgeon infected with HIV is to be allowed to start operating again in what is the first known case of its kind in the United Kingdom.

Professor George Browning, an ear specialist at the Gartnavel General Hospital in Glasgow, will conduct operations when there is deemed to be no measurable risk of the virus being transmitted to patients or staff. The intricate middle ear surgery is carried out using instruments, with no physical contact between surgeon and patient.

The decision to allow Professor Browning to return to the operating theatre was taken after detailed consideration of the circumstances by his employers, the West Glasgow Hospitals Trust, which took advice from the Department of Health's UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses.

The trust's medical director, Dr Adam Bryson, said that everyone concerned was satisfied that there was no threat to patient safety. "The public can be reassured that the Department of Health and our own experts have considered this extremely carefully and comprehensively," he added.

Patients to be operated on by Professor Browning will be asked to sign a consent form stating that they know that he is HIV positive, and anyone can ask for another surgeon if he or she wishes. The professor will be required to have frequent health checks, and during operations instruments will have to be placed on a tray rather than handed directly between him and theatre staff.

Professor Browning discovered that he was HIV positive almost two years ago and decided to make a public announcement shortly afterwards. He has been taking outpatient clinics and carrying out teaching duties for the past 18 months while campaigning to return to surgery. He said that he was delighted at the trust's decision and hoped that the positive outcome of his case would help reduce the fear faced by other HIV positive healthcare workers in revealing their condition. He said that he had been contacted by some people who were reluctant to inform their employers that they were infected with the virus: "I hope they will be reassured by my case and do what is in their own and their patients' interests."

Under current guidelines health workers who think that they may be HIV positive are advised to inform their employer. If there is considered to be no risk to patients the person concerned can continue working. Professor Browning's public declaration of his condition makes him the first known surgeon

Professor Browning is delighted at the trust's decision

to return to the operating theatre, but similar cases may have already been handled confidentially.

Professor Browning said that he was encouraged throughout his campaign by the support he received from his patients, and the decision to allow him to operate again was welcomed both by patients' and HIV groups. Patricia Dawson, director of the Scottish Association of Local Health Councils, praised the professor for the way he had conducted himself and the importance he attached to ensuring the safety of his patients. However, she said that the decision could not be seen as establishing any precedent as every case had to be judged on its particular circumstances.

Roy Kilpatrick, coordinator of the Scottish HIV and AIDS Voluntary Forum, said: "I would congratulate him for being so honest and straightforward about the issues. People who are HIV positive are more likely to come forward if they realise they will be dealt with sympathetically."—BRYAN CHRISTIE, *health correspondent, Scotsman*

Counselling has grown haphazardly

The effectiveness and cost effectiveness of offering counselling services in general practice in Britain has still to be decided, according to two new reports published this week.

The Role of Counsellors in General Practice, published by the Royal College of General Practitioners, found that, given the absence

of good research based evidence on the efficacy and effectiveness of counselling, services had grown up in a "diverse and somewhat haphazard fashion." The authors warned that general practitioners, counsellors, and clients may be "done a disservice" if better guidance is not developed to govern future services.

The authors recommend more research into the efficacy and cost effectiveness of counselling interventions in the treatment of minor psychological disorders in general practice settings; the establishment of a minimum national standard for the training of counsellors working in medical settings; and better education for general practitioners on the organisation and role of counselling services in general practice.

"It is far too early to assess effectiveness, let alone cost effectiveness of counselling services within general practice. However I'd urge any general practitioner thinking of taking on a counsellor to visit a practice where counselling services are already in place and talk to both the general practitioner and the counsellor—particularly on the issue of good communication," said report author Dr Bonnie Sibbald, reader in health services research at the National Primary Care Research and Development Centre, Manchester.

Dr Sibbald said that problems could arise over patient confidentiality, which general practitioners usually considered a team matter, while counsellors may treat it as absolute. "Failing to share the nature of the patient's problem, what action to take, report progress, or to jointly assess the need for further medical intervention may adversely affect outcome," Dr Sibbald said. "Length of treatment can also be a problem—the general practitioner expecting it to last a matter of weeks, a counsellor several years."

A second report, *Is counselling in primary care growing too fast? A clinical, economic and strategic assessment*, acknowledged that counselling is a very popular service with health professionals working in primary care, as well as with patients themselves. The report from the Institute for Health Policy Studies, at the University of Southampton, calls for recognition of a more "accessible, comprehensive and holistic package of care."

"Contact with a counsellor can help patients learn coping skills which will benefit them throughout their lives. This makes the impact of counselling particularly hard to measure, and our criteria for doing so need to be wider," said author Dr Ed Godber, research fellow at the institute. Dr Godber also emphasised the need for appropriate training and supervision of counsellors and suggested ways of better evaluating their performance in the future.—ALISON BOULTON, *medical journalist, London*

In Brief

Study finds no evidence of Gulf war syndrome: Two large studies in the *New England Journal of Medicine* have found a slight increase in the subsequent death rates among Gulf war veterans but no increase in serious illness. They found an increased death rate of 9% in veterans, mostly from car accidents, but found no excess of unexplained admissions to hospital.

EC launches research programme into BSE: A three year, 50m ecu (£38.5m; \$58m) research programme into all the transmissible spongiform encephalopathies has been launched by the European Commission. The funds will be allocated under three separate programmes—biomedicine and health, biotechnology, and animal health.

Dutch organisation calls for the legal right to suicide: The newly launched Voluntary Life Foundation in the Netherlands is campaigning for drugs to commit suicide to be available to healthy people. The group, which has 150 members, is a splinter group from the 84 000 strong Dutch Voluntary Euthanasia Society.

Transplant operation performed on youngest ever recipient: A 2 hour old infant has had a heart transplant operation after hypoplastic left heart syndrome was diagnosed in utero; the infant was delivered by caesarean section after a donor had been found. The infant will probably remain on immunosuppressants for life, and has been given an 80% chance of surviving to one year and a good prognosis thereafter.

New head of Public Health Laboratory Service announced: Sir Leslie Turnberg is to become the new chair of the Public Health Laboratory Service on 1 January. Sir Leslie has been the president of the Royal College of Physicians since 1992 and takes over from Dr Malcolm Godfrey.

Leptin may exacerbate insulin resistance: Preliminary evidence from cell culture studies shows that leptin, a peptide secreted by fat cells, may contribute to obesity related insulin resistance and some forms of diabetes (*Science* 1996;274:1185-8). The discovery of an obesity gene two years ago led to the finding that when normal mice are given leptin they lose weight. Clinical trials have now started to see whether leptin could be a useful obesity treatment.

High Court to rule on patient in near vegetative state

A health authority is to ask the High Court to allow the withdrawal of feeding from a severely brain damaged road accident victim who is not in a permanent vegetative state.

The case of a woman in whom "near permanent vegetative state" has been diagnosed is expected to provoke controversy, as the health authority is the first to seek approval for the withdrawal of artificial nutrition and hydration from a patient who is not in a vegetative state. Unlike vegetative patients, who have only reflex eye movements, the woman is able to track an object with her eyes.

James Munby, the QC regularly briefed by the Official Solicitor to represent patients' interests, revealed the pending case last week at a conference in London on the permanent vegetative state, jointly sponsored by the BMA, the Official Solicitor's office, and the Centre for Medical Law and Ethics at King's College, London. The conference was chaired by Sir Stephen Brown, president of the High Court's family division, who has presided over most of the court's "right to die" cases.

The House of Lords laid down in the case of Tony Bland—who was in a permanent vegetative state after the Hillsborough disaster—that doctors should not stop artificial feeding for vegetative patients without court sanction. It emerged at the conference that police in Lancashire and the Bristol area had contacted the BMA about two cases in which doctors were suspected of discontinuing feeding without going to court.

In one, the patient was "definitely not vegetative," according to a BMA spokeswoman. In the Lancashire case, the doctor was questioned, but the Crown Prosecution Service decided that the evidence did not warrant a prosecution. A similar decision is thought to have been taken in the Bristol case.

Mr Munby said that the court had sanctioned withdrawal of feeding in 10 cases so far, and four more were pending. He said:

"The correct question as formulated by the House of Lords in the Bland case was not whether it was in Tony Bland's interests that he should be allowed to die. The correct question is: Is it in the best interests of the patient that treatment should be continued? If not, then it is lawful for treatment to be discontinued."

In fact, Mr Munby added, it was his view that following the House of Lords ruling it was unlawful for treatment to be continued in such cases. So he was puzzled by the fact that only 10 cases had come to court, when there were thought to be 1000 to 1500 patients in the permanent vegetative state in Britain.

"Is it that large numbers of doctors are doing what the House of Lords told them not to do—discontinuing treatment without coming to court—or is it that large numbers of doctors are doing what, on one view of the law, the House of Lords has told us is unlawful?" he asked.

He predicted that the latest case would have the same outcome as the cases of the permanent vegetative state: "It may be that we will shortly come to the position where the crucial question 'Is the patient in PVS or is the patient not quite in PVS?' will become less crucial." Last year the Irish Supreme Court sanctioned the withdrawal of artificial feeding from a woman in "nearly, but not quite" permanent vegetative state for 23 years. Courts made a similar ruling in New Zealand in the case of a patient with Guillain-Barre syndrome and in Jersey in the case of a child in a non-cognitive but not permanent vegetative state.

Keith Andrews, medical director of the Royal Hospital for Neurodisability, south-west London, said that his unit's study of patients misdiagnosed as in permanent vegetative state was a cause for concern but demonstrated that clinical tools could distinguish between vegetative and non-vegetative patients (*BMJ* 1996;313:13-6).

Bryan Jennett, emeritus professor of neurosurgery, University of Glasgow, said that the requirement that every case should come to court "puts the UK in a unique position on the international scene."—CLARE DYER, legal correspondent, *BMJ*

The Scottish courts recently gave doctors permission to withdraw feeding from Mrs Janet Johnston

SCOTTISH DAILY RECORD/MSI

No need to keep taking the medicine

US doctors have successfully managed to take 40% of their elderly hypertensive patients off drug treatment by counselling them to make changes in lifestyle.

The non-pharmacologic interventions in the elderly (TONE) study found that structured counselling about losing weight and reducing sodium intake safely reduced the need for antihypertensive treatment in many older patients. The results of the three year randomised controlled trial were presented at the meeting of the American Heart Association in New Orleans last week.

The researchers recruited 975 patients aged between 60 and 80 who were already taking a single antihypertensive drug to keep their blood pressure below 150/90 mm Hg. The 585 patients who were overweight were assigned to one of four treatments: weight loss alone; sodium reduction alone; combined weight loss and sodium reduction; or usual care, which entailed no change in lifestyle. The 390 patients who were not overweight were assigned to either sodium reduction or usual care.

About three months after the patients had been assigned a treatment the doctors tried to taper and discontinue their antihypertensive drug under close supervision. Drug treatment was restarted if the patient's blood pressure became more than 150/90 mm Hg or the doctor decided that it was needed.

Patients in the weight reduction groups lost an average of 4.5-5.4 kg. Average sodium intake was reduced to about 2300 mg a day for patients who were not overweight and to about 2900 mg for those who were overweight. These reductions were well maintained during the follow up. Changes in weight and sodium intake were only small in patients not assigned to these interventions.

Sodium reduction and weight loss each decreased patients' need for treatment with antihypertensive drugs by about 40%. After 30 months of follow up almost 40% of the patients assigned to active treatment had their blood pressure under control without drug treatment. Those patients who were assigned to the combination of sodium reduction and weight loss did particularly well at maintaining control of their blood pressure without the need for drugs.

Dr Paul Whelton, study author and director of the Welch Center for Prevention, Epidemiology and Clinical Research at the Johns Hopkins School of Public Health, said: "The implications are that it is possible to get patients off their medication safely and achieve good blood pressure control through lifestyle changes." Few people dropped out of the study, and Dr Whelton acknowledged: "Perhaps people in this age range are more motivated and it may be more difficult to achieve with middle aged or younger patients."—JACQUI WISE, *BMJ*

• Further news from the American Heart Association's meeting in New Orleans is available from the *BMJ*'s web site: <http://www.bmj.com/bmj/>

Elderly patients with hypertension can often be safely taken off their drug treatment

Low triglyceride concentrations may be cardiac risk factor

Triglycerides increase the risk of coronary artery disease and heart attack at half the concentration currently considered to be safe, according to an 18 year follow up study.

Results presented at the American Heart Association meeting in New Orleans last week showed that patients with triglyceride concentrations as low as 1.1 mmol/l (10 mg/dl) were more than twice as likely to develop heart disease than those with lower concentrations.

The issue of whether triglycerides are an independent risk factor for heart disease remains controversial as high concentrations are usually associated with other changes, such as a low concentration of high density lipoprotein cholesterol and a high concentration of low density lipoprotein cholesterol. It is generally accepted, however, that fasting serum triglyceride concentrations below 2.2 mmol/l are normal.

Dr Michael Miller, an assistant professor of medicine at the University of Maryland School of Medicine, said: "People with triglyceride levels in the low hundreds had about the same risk for heart disease as those with diabetes. In the light of that we may need to re-evaluate current guidelines."

Dr Miller and colleagues analysed data collected at the Johns Hopkins hospital in Baltimore in 1977-8 on 460 men and women aged 30-80 years with suspected coronary artery disease or atherosclerosis. Between 1993 and 1995 they tracked these patients down and determined how many had died, experienced a myocardial infarction, or needed coronary revascularisation.

After adjusting for other risk factors—such as smoking, hypertension, diabetes, lack of physical activity, low concentrations of high density lipoprotein cholesterol, and high concentrations of low density lipoprotein cholesterol—the researchers found that triglyceride was an independent risk factor

for heart disease. Triglyceride concentrations were a significant predictor of heart disease at 2.2 mmol/l, 1.7 mmol/l, and 1.1 mmol/l.

Professor Gilbert Thompson, professor of clinical lipidology at the Hammersmith Hospital, said: "We have probably underestimated the importance of triglycerides in the past." Guidelines from the European Atherosclerosis Society two years ago did suggest that one aim of treatment should be to bring triglyceride concentrations below 2.3 mmol/l. "This study suggests the ideal level should be even lower, and certainly any new guidelines which are produced should take this into account," he said.—JACQUI WISE, *BMJ*

Gene locus for Parkinson's found

American researchers have mapped the general location of a gene that seems to be responsible for Parkinson's disease in a large family with many affected members. The finding brings scientists close to identifying the gene itself.

The researchers from the National Center for Human Genome Research in Bethesda, Maryland, studied a large extended Italian family in which 60 out of 592 family members were affected with Parkinson's disease (*Science* 1996;274:1197-8). They found genetic markers on chromosome 4 (4q21-q23) that were linked with characteristics often seen in Parkinson's disease, including tremors, muscular rigidity, postural instability, dementia, and other debilitating behaviours.

Dr Nicholas Woods, head of the neurogenetics group at London's Institute of Neurology, said: "Identifying the gene will give us insights into the pathology and pathogenesis of the disease." But he warned that the finding needs replicating in other families with affected members. "My guess is that it will be like Alzheimer's and motor neurone disease where only a small number of people with Parkinson's disease have the gene responsible." (See p 1278.)—JACQUI WISE, *BMJ*

Health gains status in European Union

The European Union has moved a step closer towards ensuring that the impact on public health of any of its policies is fully considered when legislation is drafted and approved.

Last week EU health ministers asked the European Commission to draw up criteria, methods, and a formal procedure to ensure that health factors are incorporated into other policy areas. The exercise is designed to ensure that health is taken into account when commission officials start the legislative drafting process and to provide appropriate information for EU governments and the European parliament when they debate and approve the union-wide laws.

The initiative builds on recent practice within the commission, where an inter-departmental health working group has been established to vet policy proposals tabled by any of the institution's 24 separate directorates general. Only two other policy areas—environment and employment—have a similar status. This ensures that they enjoy a direct input into such diverse areas as social policy, the single market, energy, transport, agriculture and fisheries, research and development, and international cooperation.

At the same meeting the European Commission temporarily adopted a less rigid strategy towards tobacco advertising. Still unable to secure the necessary governmental backing for legislation to outlaw all tobacco advertising, the commission won the support of health ministers for a non-binding resolution urging member countries to continue to coordinate their antismoking efforts.

The resolution was adopted only after Greece, one of the major recipients of EU tobacco subsidies, insisted on the deletion of a clause asking that the detrimental effects of smoking be taken into account when tobacco related policies were being considered. Anti-smoking campaigners hope that pressure to take union-wide measures will remain. The resolution specifically highlights many of the national restrictions and initiatives already taken by individual countries. It also asks the commission to carry out surveys of best practice and to examine what further action could be taken by the union to support such trends.

The ministerial resolution was adopted just 24 hours before the commission held its first internal debate on its own approach towards tobacco. Prompted by the social affairs commissioner, Padraig Flynn, the exercise was designed to consider the economic and medical contradictions of paying producers of poor quality tobacco EU subsidies of 993m ecus (£763m; \$1144m) a year, while allocating just 15m ecus annually to discourage smoking.

The tobacco supporters successfully fought off Mr Flynn's attacks, but he will renew his offensive later this month when he is expected to table proposals to lower the nicotine content of cigarettes and to strengthen health warnings on tobacco products.—RORY WATSON, *European Voice*, Brussels

East London general practitioner Dr Chris Dobbing extends his begging bowl outside the Royal London Hospital. The City and East London Health Authority, which provides services to his patients, has a projected deficit of £22m (\$33m) this year and has said that it cannot fund routine referrals until the next financial year.

German doctors protest against "organ tourism"

Doctors in Germany have called for an end to "organ tourism" after two patients died from severe postoperative septic shock less than a month after they had had kidney transplant operations with organs from living donors in India.

Professor Thomas Philipp, from the University Hospital in Essen, where the two patients died, wrote in an article in the *Deutsche Medizinische Wochenschrift* that he knew of 25 such cases. He urged industrial countries "to pass suitable laws to prohibit organ tourism" and to take measures "to protect the impoverished populations of developing countries from being misused as organ banks for the rich countries of the world."

Professor Philipp's coauthor Dr Ulrike Met-Kurschel said in the news magazine *Der Spiegel*: "Doctors inadvertently keep organ trade booming by providing the follow up treatment to organ buyers without which they would not survive." Dr Met-Kurschel said that she would not deny treatment to these patients but called for their legal prosecution.

But Professor Walter Land, a transplant surgeon from Munich, said that it is not the desperate patient on a long waiting list who should be blamed, but rather "the criminal alliance between traders, doctors, and hospitals," which makes organ trading possible.

An increasing number of Germans with kidney failure are seeking help at commercial transplantation centres in developing countries such as India, Pakistan, Iraq, and the Philippines as waiting lists for kidney transplantations in Europe grow longer, and

patients have an average wait on dialysis of three years. The German Organ Transplantation Foundation knows of 47 such cases.

Professor Philipp estimates that up to 60% of patients with donor kidneys bought in India suffer the consequences of poor transplantation practice. In particular the necessary HLA matching between donors and recipients seems to be widely neglected. Instead the patients are given heavy overdoses of immunosuppressants such as cyclosporin A, prednisolone, and azathioprine to prevent rejection of transplant tissue, at least during the first days, and to get patients out of the hospital as soon as possible.

Although patients can depend on a higher standard of follow up on their return to Europe, the reported first year mortality is 10-19%. That is about 10 times higher than that of recipients of kidneys from non-living donors, when the operation is performed in Europe.—HELMUT L KARCHER, *medical writer*, Munich

Kidney donation rules expanded in Israel

Non-relatives can now donate their kidney for transplantation under new regulations that have come into force in Israel. The decade old law that used to allow only parents, children, or siblings to donate a kidney to a relative has been expanded to allow a spouse, grandparent, uncle, aunt, grandchild, or cousin to be a live donor.

Health minister Tzahi Hanegbi said that people would also be allowed to donate a lobe of their lung or liver to a relative who needs it, instead of forcing them to go abroad for such surgery. He said that even a non-relative could donate an organ if the arrangements were strictly supervised to prevent the sale of organs.

The health minister made the decision at the recommendation of the country's Supreme Helsinki Committee, which consists of ministry administrators, public hospital directors, jurists, and Jewish, Moslem, and Christian clergy.

The Israel Medical Association, however, has voiced scepticism about the new rules, saying that it would be hard to prevent abuse. Association chairman Dr Yoram Blachar said that the government should instead invest more effort in encouraging donations of cadaver organs. Only about 160 kidney transplants are performed in Israel annually, but 1000 patients are waiting for the operation.

Mr Hanegbi expects the number of donations to double as a result of the change. Many Israelis are reluctant to bequeath their organs because of superstition, fear of death or religious laws. Jewish law regards saving a life as of supreme value, but some rabbis fear doctors would remove an organ before a patient's death; others recognise death as when the heart stops beating rather than as the cessation of lower brain function.—JUDY SIEGEL-ITZKOVICH, *medical correspondent*, Jerusalem Post

Britain fails to stop 48 hour week limit

Britain failed to have the European Union's working time directive annulled by the European Court of Justice last week. Even though junior doctors are exempt from the directive, they hope to use the ruling to put pressure on the government to reduce working hours.

The directive must be implemented by 23 November this year. It stipulates that no one should have to work more than 48 hours a week, except by mutual agreement and provided that there are specific safeguards to prevent abuse.

The various exemptions in the directive will effectively preclude all doctors from having to comply. Doctors in training are excluded, general practitioners are not covered because they are self employed, and consultants come under the exemption for "managing executives or other persons with autonomous decision making powers." Other workers in hospitals are allowed to make special arrangements with their employer if longer hours are worked.

Britain has the highest percentage of full time employees working more than 48 hours a week in the European Union. The British government argued that the directive was illegal because it was adopted as a health and safety issue and therefore subject to qualified majority voting, which Britain cannot block. The government has never accepted that the directive is justified on health and safety grounds.

In its legal challenge the British government also used a review of the scientific evidence by Professor Malcolm Harrington from the Institute of Occupational Health, University of Birmingham, which concluded that there was not enough evidence to stipulate a fixed maximum number of working hours. But Professor Harrington criticised the use of his report in this way and said: "This is unquestionably a health and safety issue. There is no doubt that working long hours is detrimental to health."

Many junior doctors believe that they should be included in the directive, but the BMA's Junior Doctors Committee conceded at its last meeting that a maximum 48 hour working week would be impractical for all doctors (5 October, p 886). Committee chairman, Dr Peter Bennie, said: "Forty eight hours is perfectly deliverable across

Junior doctors' leaders hope to use the directive to put pressure on the government to cut working hours

many European countries, and we are 100% behind the limit for European doctors, but at present this is not possible in Britain because there are simply not enough doctors at junior or consultant level to achieve it." But he believes that the directive will put extra pressure on the government to apply the new deal target—that by 31 December no junior doctor should be working for more than 56 hours.—CAROLINE WHITE, *freelance journalist, London*

Alternatives to "999" emergency service sought

Proposals for improving emergency services in England, both inside and outside hospital, emerged this week from the Department of Health as a basis for consultation.

The first set of proposals is from a review group headed by the chief medical officer, Sir Kenneth Calman, and deals with emergency care services in the community. The review was prompted by concern that existing systems of emergency care may be too focused on traditional access points, such as "999" calls, family doctors, and accident and emergency departments of hospitals.

The alternatives proposed would reduce strain on these facilities.

The review group supports such initiatives as education campaigns to increase public awareness of how to deal with emergencies and where to seek professional help; telephone helplines to guide people to local services; and emergency care planned and managed to be accessible 24 hours a day. Further research is recommended into the viability of alternative models.

The group believes that examples of innovative practice around the country have the potential for an improved national system of emergency care responsive to local need. Making the best use of the resources in primary and social care is central to developing a good community emergency care service, it is stated.

Secondly, the health secretary, Stephen Dorrell, has proposed a new standard in the patient's charter for accident and emergency departments. The current standard provides for patients "to be seen immediately and have their need for treatment assessed." This target is met by 93% of departments. The proposed revision is for patients to be assessed by a doctor or trained nurse. Those needing immediate treatment will be assessed at once, others within 15 minutes of arrival. Patients will then be given a priority category that will determine the urgency of treatment.

Further discussion between the department and the professions has begun on proposals for a standardised triage system that could form the basis for a national "time to treatment" standard.

Mr Dorrell said the aim is to have a standard for accident and emergency departments that is more tailored to individual needs. The present standard ensures that everyone sees a doctor or nurse quickly. In future, patients should also know that the length of time they have to wait for treatment is related to their clinical need. Work on assessment priorities is being led by the British Association for Accident and Emergency Medicine and the Royal College of Nursing. — JOHN WARDEN, *parliamentary correspondence, BMJ*

Key points of the directive

- 48 Hour working week for most employees
- Minimum daily rest period of 11 consecutive hours in every 24
- Rest break when the working day is longer than six hours
- Minimum rest period of one day a week
- Three weeks of annual paid leave (four from 1999)
- Night work not to exceed an average of eight hours
- Free health assessments for night workers
- Exemptions include: transport sector (air, rail, sea, roads), doctors in training
- Special arrangements are allowed for: senior managers and executives, the self employed, family workers, people working in hospitals, prisons, docks, airports, security, the media, emergency services, agriculture, utilities, and tourism

Legal rights for patients demanded

The patient's charter falls short of giving patients real rights in terms of access to health care, quality of treatment, and genuine choice, according to the Association of Community Health Councils for England and Wales, which launched its own manifesto for patients this week.

The patients' agenda proposes a set of rights that are not included in the patient's charter. It criticises the charter for offering only expectations of care; instead it proposes rights for patients that will be backed up by an independent health rights commission with statutory powers.

Proposals in the agenda include an automatic right to an explanation if a patient is removed from or refused access to a general practitioner's list; the right to be accommodated in a single sex ward if preferred, without delaying treatment by more than four weeks; and the right to choose a hospital and consultant using meaningful information. The right to free eye tests and dental check ups is also included.

Mr Jim Johnson, a vascular surgeon and chairman of the BMA's Central Consultants and Specialists Committee, said that the proposals were "unrealistic" without a lot more funding. He was also sceptical about whether such rights could be enforced by a body that had no control over funding of the health service. However, he did agree that the existing patient's charter is unsatisfactory. "The charter was designed to give the impression of delivering care without in fact delivering very much," he said.

Philip Hunt, director of the National Association of Health Authorities and Trusts, acknowledged most of the aims of the agenda as laudable while pointing out that both patients and patients' organisations have a part to play. He said: "This agenda would have more credibility if it said more about the right we have to expect patients not to abuse the service or make unnecessary calls on it."

Another of the suggested rights is to have an experienced accident and emergency doctor on duty or available on site at all times to safeguard the quality of emergency treatment. On this Mr Hunt commented: "If community health councils were supportive of mergers of A&E [accident and emergency] departments then it would be more likely that such an aim could be achieved."

Toby Harris, director of the Association of Community Health Councils for England and Wales, defended the patients' agenda, saying that it was designed to redress the balance of power between the medical profession and the patients. He said: "We have identified issues that are important to patients, and I believe in a modern health service we should be able to achieve this agenda."—KATHRYN GODFREY, *medical journalist, London*

• The Patients Association this week called for an end to mixed wards in the NHS. The organisation is commissioning research into the cost of closing all mixed wards.

Patients are demanding rights backed up by law

Australia puts curbs on foreign doctors

The Australian federal government is clamping down on foreign doctors, claiming that some are cheating the immigration system to get in via the back door.

The minister for health, Dr Michael Wooldridge, has banned doctors who have just arrived in Australia from entering general practice for at least 10 years in an attempt to cut the oversupply of general practitioners in urban areas. The plan means that the doctors, including those from New Zealand and full fee paying foreign medical students, will not be given access to the government's Medicare system.

The move is expected to reduce the number of doctors entering Australia from 600 to 100 a year. The countries most affected will be India, Fiji, Sri Lanka, Egypt, Ireland, and Lebanon.

"We have been mugs to allow ourselves to be one of the last Western countries to allow unrestricted medical migration," said Dr Wooldridge, claiming that it was "killing Medicare" by pushing up costs. But he said that foreign doctors would still be able to work in salaried positions in public hospitals if they passed the Australian Medical Council examinations.

The minister said that New Zealand seems to have been used as a staging post by some doctors to get into Australia. He also claimed that he was "suspicious" about some of the 350 doctors who were granted entry after marrying Australians.

Dr Wooldridge said that Australia already had 4500 general practitioners too many in the large cities. But there was also an undersupply of 500 doctors in rural areas caused by a reluctance of many general practitioners to go into the outback.

The Australian Medical Association has backed the ban but said that the training sys-

tem still had problems. "In the long term it will have a substantial effect ... but the numbers of graduates has to be matched with the training places," warned the president of the association, Dr Keith Woolard.

The Australian Doctors Trained Overseas Association said that the problem was caused not by oversupply but by a poor distribution of the doctors' services. "But the government and the finance department wants to create an atmosphere of fear and a sense that the system is in crisis," it said.—CHRISTOPHER ZINN, *Australian correspondent, Guardian*

Ontario doctors stand firm against government

The professional medical bodies in Ontario are standing firm against the provincial government's attempt to divide and rule in the continuing battle over planned cuts in the healthcare budget.

Doctors rejected the government's latest proposals for reform in a province-wide referendum, and some started refusing to accept new non-emergency patients in protest. Last week the health minister asked the College of Physicians and Surgeons to discipline such doctors, but the college refused.

Dr Gerry Rowland, president of the Ontario Medical Association, applauded the college's stand. "The best way for the minister to ensure patients receive quality medical care is not by threatening or legislating doctors into submission but by working with doctors to find fair and reasonable solutions in the best interests of our patients," he said. "I urge the minister to focus his attention on the fundamental problem facing our patients—the chronic underfunding of medical services."

Dr Helen Gordon, president of the college, said in a letter to the minister that the college's decision was a result of a "real concern for the long term effects that misusing the regulations of the college in this way would have on the important principles of self government, accountability, and autonomy."

The latest proposal by the government is to pay the doctors 97.1% of the fees that they are allowed to charge for approved services rather than the 90% that they had been paying—reducing the "clawback" from 10% to 2.9%. The government also agreed to restore the subsidies that it had been paying for premiums on malpractice insurance, which it had suddenly stopped paying last year.

The sticking point for the medical profession, however, was the government's proposal that doctors could not claim fees from the provincial insurance plan if they opened a practice in an area that was considered to have too many doctors already. Doctors saw this as an unacceptable restraint on their independence and rejected the whole plan.

The Ontario Medical Association has launched a radio campaign to gain public support for its action.—DAVID SPURGEON, *medical journalist, Quebec*