US doctors oppose participation in executions

Groups representing physicians and other health professionals and two human rights organisations in the US are taking a strong stand against the participation of health professionals in executions. A long report, *Breach of Trust: Physician Participation in Executions in the United States*, has been issued by four organisations: the American College of Physicians, which represents more than 80 000 internists; Physicians for Human Rights, which has about 4000 members; Human Rights Watch; and the National Coalition to Abolish the Death Penalty. A joint statement has also come from the American College of Physicians, the American Medical Association (AMA), the American Nurses' Association, and the American Public Health Association, saying that participation in state executions (federal executions are rare) "contradicts the fundamental role of the health care professional as healer and comforter."

Breach of Trust documents the current situation. Of 36 states with death penalty statutes, 23 require a physician to "determine" or "programme" death and 28 have statutes or regulations requiring a physician's presence at an execution. What has brought this issue to the fore is the increasing use of lethal injections for executions. Considered to be more "humane," this practice is now allowed by 25 states, and doctors have been recruited to help.

In 1992 the AMA, acting on a resolution introduced by the American College of Physicians, passed ethical guidelines that clarified its general proscription, dating from 1980, against doctors' participation in executions.

The guidelines forbid actions by a physician that cause the death of a condemned person (for example, giving a lethal injection); help another person to cause death (for example, prescribing the drugs necessary for a lethal injection); or could automatically cause an execution to be carried out on a condemned prisoner (for example, determining whether death has occurred during an execution). Included in such actions are the prescribing of psychotropic drugs as part of the execution process (as opposed to relieving a prisoner's anxiety before an execution); monitoring vital signs; attending or observing an execution as a physician; and helping with lethal injections. Excluded is certification of death after someone else has declared a prisoner dead.

Among the 36 states with the death penalty, says *Breach of Trust*, the state medical societies of 10 have specific policies against partici-

The death chamber: doctors are used to make the killing more "humane"

pation by a physician. In 18 other states medical societies defer to the AMA's guidelines on the issue. Moreover, state medical practice acts regulating physicians' conduct often state that certain conduct is unethical. Even so, in these same states laws mandating the help of a physician in an execution often exist. Theoretically, a physician asked to participate in an execution could violate state law no matter what action he or she took.

In reality, state medical societies hold sway only over their members; it is the state medical licensing boards that can discipline a physician. As yet, however, none has disciplined a physician for participating in an execution.

"Execution is not a medical procedure," *Breach of Trust* states. "Physicians are committed to humanity and the relief of suffering; they are entrusted by society to work for the benefit of their patients and the public. This trust is shattered when medical skills are used to facilitate state executions."

The health organisations want state legislatures to change their laws requiring physicians to participate in executions. "Most of these are probably old laws whose intent was to avoid cruel and unusual punishment of prisoners," said Mike Ile, health law division counsel of the AMA. "We don't disagree with that sentiment, but it's time for a change." The groups also want state medical societies to adopt the AMA's guidelines and to put pressure on state medical boards to discipline physicians who violate these ethics.—GAIL MCBRIDE, medical journalist, Chicago

French doctors puzzle over gene ownership

French doctors are facing an ethical dilemma over the question of who owns the genes in a special gene bank dedicated to research into diabetes. The genes were collected by the non-profit making Centre d'Etudes de Polymorphisme Humain (CEPH) for the study of genes related to diseases. The centre, which was founded by the Nobel prize winning physician Jean Dausset, launched a special appeal four years ago for diabetic patients and their relatives to donate blood to it. About 5500 people responded, and it is those samples, which now form a gene bank, that are the source of the confusion.

Because, he said, France lacks money to exploit the data on diabetes effectively or rapidly, the director of the CEPH, Dr Daniel Cohen, proposed handing over the gene bank to an American pharmaceutical firm. Dr Cohen is a cofounder and shareholder in the firm Millenium Pharmaceuticals. Opponents of his proposal claim that the genes do not belong to the CEPH and that exploiting the data for profit would penalise French research.

The gene bank was set up by Dr Pierre Frogel, a diabetologist with the public hospitals in Paris. Research on the samples has already led to the identification of an important gene coding for the enzyme glycol kinase.

Headlines

Moves to ban smoking in workplaces

in US: The Clinton administration is proposing to ban smoking in all workplaces, including offices, restaurants, cafes, and bars. If the proposal becomes law it would apply to more than six million workplaces and 4.5 million non-industrial sites. Smoking indoors would be allowed only in enclosed, designated areas.

US tobacco firm sues TV company

for libel: Philip Morris Tobacco has filed a \$10bn libel lawsuit against the ABC television network for what it says were false and defamatory statements alleging that cigarettes were "artificially spiked" with nicotine to keep people smoking.

European lobbyists call for health

forum: The European Public Health Alliance, which represents lobby groups concerned with issues such as smoking, accident prevention, and nutrition, has called for an open forum of health professionals, patients' groups, and government representatives to advise the European Commission on health policy.

Dutch consumers criticise waiting

lists: An inquiry by the Dutch consumers' union has found that hospital waiting lists are too long. There is an average wait of four weeks, but patients are waiting several months for orthopaedic surgery; ear, nose, and throat treatment; and gynaecological treatment. The introduction of hospital budgeting in 1986 has limited the number of operations performed. Last year a report on Dutch health care suggested that waiting lists were not always bad as they improved hospitals' efficiency.

France withdraws blood products:

The French Ministry of Health has decided to withdraw blood products donated by people who have gone on to develop Creutzfeldt-Jakob disease. The measure is said to be a precaution to avoid the transmission of prions—no contamination of blood products has so far been discovered.

British teenagers to get diphtheria

booster: A routine diphtheria booster vaccination for British teenagers is to be introduced this year to guard against an epidemic that has occurred in eastern Europe. Two protected people in Britain have developed mild forms of the disease. The new booster will be combined with a vaccination against tetanus.

DNA profiling: different laboratories use different databases

TODAY/REX FEATURES

Dr Cohen's proposal would have given Millenium exclusive access to the DNA in exchange for a small share of royalties on any resulting commercial products. But the CEPH's board of directors asked for a "more equitable agreement." Dr Cohen then suggested that the DNA databank should be placed in the public domain. He also asked for Dr Frogel's collaboration with the CEPH to be discontinued for "internal and relational reasons." Dr Frogel has now written to the prime minister, Edouard Balladur, protesting that the DNA, obtained from volunteer donors, does not even belong to the CEPH.

Professor Jean François Mattel, a member of the French national ethics committee, admitted that DNA banks operate "in a total jurisdictional vacuum." Professor Mattel, who is also a government consultant on bioethics legislation, believes that the use of publicly funded research for profit would be unethical. He will propose an amendment to the bioethics bill that is expected to pass its second reading at the National Assembly shortly. The amendment is likely to specify that "the knowledge of the total or partial structure of a human gene cannot be the object of a patent."

The Ministry of Higher Education and Research also took action, forming an expert committee of scientists and jurists to solve the question of ownership of the CEPH's diabetic databank. In the past the French have been vocal in their opposition to the patenting of uncharacterised genes and gene fragments. Now that the National Institutes of Health in the US has backed down from its application for a patent for a few thousand such uncharacterised sequences, it would be awkward for the French to exploit their genes, likewise uncharacterised, from diabetic patients.—ALEXANDER DOROZYNSKI, medical journalist, Paris

DNA evidence may have been misleading to courts

Courts are being misled about the strength of evidence based on DNA, according to two mathematicians writing in last week's issue of *Nature*. David Balding and Peter Donnelly, of Queen Mary and Westfield College, London, argue that the adversarial nature of the British legal system and the "siege mentality" of some forensic scientists have often led to evidence being presented in a partisan and misleading way.

The article points out a common "prosecutor's fallacy" when the probability of guilt is assessed in the light of a possible match between samples of DNA. The strength of a correlation between the DNA of the accused and the DNA of the crime sample is expressed by forensic scientists as a "match probability"—the probability that a randomly chosen unrelated person from the relevant population group will match the sample as closely.

Match probability gives the chance that a person will match, assuming he is innocent. But courts need to know whether a defendant is innocent, given that his DNA matches. The prosecutor's fallacy is to give the answer to the first question in response to the second. This is to confuse the match probability with the probability of innocence, say Balding and Donnelly. The odds of guilt depend heavily on the strength of supporting evidence and the number of possible culprits.

In the recent appeal of Andrew Deen, whose conviction for rape was quashed at the Court of Appeal, the forensic scientist described his match probability as the "probability of the semen having originated from someone other than Andrew Deen." He later told the court that "the likelihood of [the

source of the semen] being any other man but Andrew Deen is one in three million." This misrepresentation of the probabilities was one of two reasons given by the Court of Appeal when it quashed the conviction. The other was the judge's summing up of a dispute about the quality of the DNA match. In ordering a retrial the lord chief justice, Lord Taylor, said that he did not wish to discredit DNA profiling in future cases.

Because DNA profiling is widely believed to be almost infallible, cases are often brought with little corroborating evidence. Balding and Donnelly point out that in these cases, especially, a very small match probability does not necessarily indicate a very small chance that the defendant is innocent. They give a hypothetical situation in which a suspect is found to have a match probability of one in one million and the crime took place in a large city with 500 000 other people who could potentially be the guilty party. Unless other evidence points to the defendant, the DNA profile still leaves a one third chance that he is innocent despite the exactness of the match.

The different population databases used by various laboratories can lead to different calculations of match probability even when the pattern of the bands is agreed on. Moreover, the current system overlooks the problem of the defendant's relatives unless they are also suspects: relatives have a far higher chance of mirroring the defendant's profile than the match probability would suggest. Balding and Donnelly acknowledge the value of DNA profiling in supporting other evidence and in eliminating suspects, but they argue that early enthusiasm for the technique has led to too much reliance being placed on it as a foolproof way to find the guilty man.—OWEN DYER, freelance journalist, London

More US graduates opt for primary care

More medical school graduates in the US this spring looked into their future and chose primary care. After almost a decade of losing graduate students to medical and surgical specialties, primary care specialties have made a strong comeback this year.

On 15 March, after months of interviewing, applying, and waiting, senior medical students in the US were handed confirmation of their choices of where they would spend their next few years of postgraduate training. For most, that was the day they committed themselves to a specialty. And, for the first time since 1988, more than half (51.6%) chose primary care specialties: internal medicine, paediatrics, obstetrics and gynaecology, and family practice. In the US only about 35% of doctors practise primary care, although President Clinton and health policy leaders have called for 50-55% to do so.

For family practice it was the best year in the specialty's history: 13% of the 14 207 graduates chose it. In fact, family medicine's training programmes have grown by 15% this year, after a record 19% increase last year,

according to data released by the National Residency Matching Program. "Primary care is in," said Dr William Coleman, president of the American Academy of Family Physicians. He said that three factors were responsible for the reversal of the long trend toward specialisation. Firstly, policy leaders and the media have focused on the need for primary care doctors, and some are even proposing eventually to force trainees into primary care. Secondly, he said, more medical schools have opened family medicine departments, and more are offering clerkships in family medicine. In fact, since last year, all medical schools must offer some type of education in family medicine. Finally, he credited his organisation with having lobbied students to take up careers in family medicine.

Another reason for the migration from subspecialties may be money. Since the recent introduction of new government payment schemes for doctors and the growth of "managed care" in the US, salaries for primary care doctors have grown substantially while those of subspecialists have been falling.

Data from this year's matching are not complete, but there is some indication that losses will occur in specialties such as radiology, anaesthesiology, and neurology. The number of students entering one year programmes in preparation for those specialties fell 7% this year. The number entering surgery has dropped 4% compared with last year.

Although the news is good for primary care, policy leaders have expressed some concerns. For example, about two thirds of students choosing primary care may still become specialists. Internal medicine, paediatrics, and obstetrics and gynaecology can be primary care specialties or the foundations for subspecialty training in, for example, cardiology, endocrinology, and reproductive medicine. In the past about half of trainees going into those three specialties have gone on to subspecialty training.—JOHN ROBERTS, North American editor, *BMJ*

Ethnic minority doctors more likely to face GMC

Doctors from ethnic minority groups in Britain are six times more likely than white colleagues to be brought before the conduct committee of the General Medical Council (GMC), according to research released last week by the Medical Practitioners' Union. Dr Sam Everington and Dr Aneez Esmail found that between 1982 and 1991 a total of 402 doctors had been brought before the committee, of whom nearly 60% were from ethnic minorities. Fewer than one in five doctors in Britain is from an ethnic minority.

The authors, who studied data collected from the minutes of the committee's proceedings, used doctors' surnames to estimate the number from ethnic minorities. "If anything, our figures underestimate the imbalance," said Dr Everington. "We worked on the assumption that most doctors from ethnic minorities are Indian or Pakistani. We are not saying that these doctors did not deserve disciplining. We believe that the GMC probably does not discipline enough doctors and that white doctors are getting away with conduct that brings doctors from ethnic minorities before the conduct committee. White doctors know the system and cope better with complaints at all levels, from patients through to family health services authorities and district health authorities."

Dr Everington urged the GMC to hold an inquiry into the research findings. Sir Robert Kilpatrick, president of the GMC, said: "I am satisfied that, having received a complaint about a doctor, all subsequent actions by the council are completely free from racial discrimination."

Mr Roger Sims, a Conservative member of parliament and a lay member of the GMC, also dismissed the idea that racial discrimination was an issue. "When the complaints are

US graduates are finding primary care more attractive

screened at the preliminary procedures committee we look at each case to see if it's a potential disciplinary matter—at this stage it's all on paper. I don't know how you could be sure of ethnic background. It's not the GMC that makes the complaints; it's the public. There may be racial discrimination on the part of patients who complain."

Dr Aneez Esmail said: "The GMC always responds to criticism by saying 'It's not our fault.' This time it is saying, 'It's the public's fault.' It's incredible that a self regulating body can have this imbalance and not show concern. When you look at hard charges brought before the committee—such as improper prescribing of drugs—there is not much difference between white doctors and those from ethnic minorities. But doctors from ethnic minorities are far more likely to be charged with indecent behaviour, while white doctors are accused of forming improper relationships with patients."

The findings of the research have been sent to the Commission for Racial Equality. A spokesperson for the commission said that it had statutory powers to investigate only individual complaints. It could, however, make recommendations if invited to do so by the GMC. Of the GMC's 102 members, six are from ethnic minority groups.—LUISA DILLNER, *BMJ*

Hepatitis B status must be known for medical school

All students who are offered places at medical school will have to provide certificates to show they have been immunised against hepatitis B before they can start their courses. Those students who are infective carriers of hepatitis B virus will not be allowed to study medicine (see editorial on p 870).

The Committee of Vice Chancellors and Principals (CVCP) issued guidance last week on immunisation to the Universities and Colleges Admissions Service (formerly UCCA) after receiving advice from the Council of Deans of United Kingdom Medical Schools and Faculties. The admissions service will include the information in its handbook for applicants.

The guidance states that "medical schools are mindful of their overriding duty of care to the public with whom medical students come into close contact at an early stage of their studies." It says that all the deans have agreed that successful applicants must have proof "of non-infectivity and immunisation against hepatitis B by the time of registration." The guidance is likely to come into force by autumn 1996 and will also apply to dental students. Frank Harris, executive secretary of the council of deans, said, however, that medical schools were autonomous and that it was up to them to consider individual cases.

Although the guidance does not spell out the definition of "infectious," one dean said that it was likely to include students who carried the e antigen without carrying the

antibodies to that antigen that would make them non-infective.

The BMA's Medical Students Committee has criticised the CVCP's move as alarmist, unnecessary, and discriminatory. Some medical schools, which currently test students in their first year before they begin clinical work, say that the current system works well and does not need to be changed.

The Medical Students Committee says that it firmly supports a universal and rigorously applied vaccination programme among medical students. But it believes that students who are infective carriers should be allowed to continue on a modified course that excluded procedures that could put patients at risk. They would still be able to follow careers in specialties such as psychiatry, epidemiology, pathology, microbiology, and public health. Rupert Gauntlett, BMA student representative at Leicester Medical School, said: "To do something as radical as completely closing the door to medical school represents a tremendous overreaction."

Until now medical schools have made special arrangements for students who are infective carriers of the hepatitis B virus, allowing them to follow modified courses. The council of deans has now said, however, in a letter to the Medical Students Committee, that "it is not generally accepted that the course can be suitably modified." Yet a spokesperson for the General Medical Council, which has to approve all courses leading to a medical degree, said that such modifications are "under active consideration."

Vaccination against hepatitis B requires three injections. The second and third injections are usually given one month and six months after the first, although they can be given at one month and two months. Sixth formers who are interested in applying for medical school are advised to start a vaccination course in the lower sixth.

Andy Hall, senior lecturer in epidemiology at the London School of Hygiene and Tropical Medicine, says that 95-98% of

people will seroconvert after three doses and more after additional doses. But 1-2% will never seroconvert and therefore remain susceptible to infection.

The prevalence of hepatitis B carriers among people born in Britain is 0.5% or less—and could be even lower among 17 to 18 year olds. But in many parts of the world, including much of Africa and Asia, the prevalence in the general population is as high as 10-20%. Although the guidance deals with infective carriers, some deans believe that the number of infective carriers is also higher in these parts of the world.

Mark Bailey, chairman of the Medical Students Committee, said: "We see this policy as discriminating against people who have a problem which is quite likely no fault of their own, and which we think does not prevent their ability to follow a medical job in the future."

The ruling follows guidelines on hepatitis B vaccination of health care workers issued to health authorities and trusts last August by the NHS Management Executive. These say that health workers who are infective carriers of hepatitis B virus must not perform "exposure prone procedures" in which there is a risk that injury will result in their blood contaminating a patient's open tissues. It does not, however, exclude them from practising medicine.—SHARON KINGMAN, freelance journalist, London

● A survey last year of senior medical students in the US showed that 97% had been immunised against hepatitis B, according to a spokesman for the American Association of Medical Colleges (AAMC). Since 1992 the AAMC and the medical school accrediting agency have insisted that schools should follow guidelines set out by the Centers for Disease Control and Prevention, which say that health care workers exposed to patients should be immunised. The AAMC's spokesman said that students were usually immunised just before they started their clinical studies in their third year of school.

So far medical students have been immunised against hepatitis B after arriving at medical school

ULRIKE PREUSS

India's AIDS control programme is unsatisfactory

The number of people found to be HIV positive in India has increased by 25% in the past year, and the number of people with AIDS has nearly doubled. The official figures are that there are 15 000 people who are HIV positive and 559 people with AIDS. But the secretary of the Indian Health Organisation, Dr Gilada, paints a grimmer picture. He says that 2 million people are HIV positive and 100 000 people have AIDS. By 2000 there will, he says, be 30 million to 50 million HIV positive people and 3 million to 5 million people with AIDS.

The health minister, Mr Shankranand, admitted in parliament last month that the national AIDS control programme was not progressing well. But the 2250m rupees (£50m) that the programme has budgeted for AIDS control for 1992-7 has been under-spent by between 14% and 32% in most states. The funds must be used solely for combating AIDS, and India has to give a similar undertaking to the World Bank for the \$84m (£56m) that forms part of the total budget.

Educationalists and health experts are warning that sex education in schools needs to be improved, particularly as India's traditional attitudes towards sex have been eroded by rapid socioeconomic growth. Those who plan the curriculum are conscious of the controversy over whether to introduce the topic of sex and AIDS in schools.

The problem of HIV infection will continue to grow unless the main routes of transmission—blood transfusion, heterosexual contact, and the use of infected needles by drug users—are tackled. Of 1018 blood banks, only 180 are equipped with facilities for detecting HIV. It has been impossible to check effectively professional blood donors, a common source of HIV infection, because a lot of blood is collected from them and there is already a shortfall of 21 million bottles.

Truck drivers operating on national highway routes have played an important part in spreading infection. Limited studies have shown that they frequently visit red light districts in Delhi and Bombay. In Delhi alone 50 000 to 60 000 trucks stop at different highway points.

The incidence of HIV infection varies in different states. In the north eastern states of Manipur, Nagaland, and Mizoram heroin is easily available across the border. The Indian Council of Medical Research reports that 1-2% of the general population in these states are intravenous drug users and about half the users are HIV positive. Out of an estimated 15 000 intravenous drug users in Manipur, a fifth may develop AIDS within the next five years.

Voluntary organisations are trying to educate the target groups not necessarily to change their lifestyle but to practise safe sex by using condoms. To this end the Ministry of Health and Family Welfare has decided to improve the quality of condoms.—ZAKA IMAM, medical writer, Lucknow, India

Sex workers in India are not being protected by the government's AIDS programme

NAHAT calls for more GP training

General practitioners need updated training and continuing education if they are to meet the challenges of expanded primary health care and the advances in medical technology, says the National Association of Health Authorities and Trusts (NAHAT). The association wants the training period for principals in general practice to be increased to five years: a three year period of general professional (vocational) training for all doctors in general practice followed by a two year period of higher training. The association is also calling for health authorities to recognise membership of the Royal College of General Practitioners (or an equivalent qualification) as the standard to aim for among principals.

The recommendations are contained in a discussion paper, *Partners in Learning*, which the association has sent to government ministers and to the chief medical officer. The paper says that training and education for general practice are in advance of training for hospital doctors in some ways but not others.

The paper also talks of amending the rules for filling singlehanded practices to ensure that only "appropriately qualified and experienced" applicants are appointed. The director of NAHAT, Philip Hunt, said: "Frankly, I think the days of the singlehanded GP are numbered. Given the burden we are placing on primary care and the need to develop teams with a range of professions and facilities, I don't believe singlehanded GPs can be expected to provide the kind of services we are going to require."

But John Chisholm, deputy chairman of the General Medical Services Committee, the general practitioners' committee of the BMA, said that the days of singlehanded general practitioners were definitely not

numbered: "Many patients still value the continuity of care that is more easily available in a singlehanded rather than a group practice. "Being in a singlehanded practice can make a doctor more professionally isolated, and we need support systems which make it easy for the singlehanded practitioner to make full use of all the educational opportunities."

The paper also proposes periodic assessment of general practitioners' performance. The association also suggests that an independent assessor should be included on the appointment panels for all principals in general practice.—CLAUDIA COURT, *BMJ*

Partners in Learning is available from NAHAT, price £5 (members) or £7 (non-members).

Germany agrees community care scheme for elderly

The political parties in Bonn have finally agreed on a new community care scheme for elderly people after several years' debate. The opposition parties had to be included in negotiations because both houses of parliament in Bonn will have to approve the new law on the scheme and the government coalition does not have a majority in the upper house, the Bundesrat.

The community care scheme is intended to give financial support to families that take care of an elderly person or to pay the full costs for elderly people who need full time care in nursing homes. These costs are not covered by the social health insurance system.

Although none of the political parties denied the necessity of a community care scheme like this, the question was how to finance it. The Bundestag, the lower house of

parliament in Bonn, passed a bill in October which stated that the scheme had to be financed by wage cuts to workers, employees, and civil servants or, alternatively, by their taking two days less leave each year. But the idea that workers and employees alone had to carry the financial burden for the new insurance scheme was unacceptable to the Social Democrats.

Under the new agreement the costs of the scheme will be compensated for by making Whit Monday—currently a holiday—a working day. To achieve this, however, the minister presidents of the 16 German states had to make a compromise: Minister President Edmund Stoiber of the state of Bavaria insisted that every German state that did not wish to give up Whit Monday as a holiday could charge workers and employees alone with the costs. Bavaria seems to be the only German state that intends to take this choice. If the Bundesrat accepts the forthcoming bill, as is commonly expected, payments for home care could be taken up by 1 April 1995, and those for nursing home care by 1 July 1996.

The most gloomy comments came from the economists and industry, who forecast

the collapse of the social system and worsening of the current state of German industry, which is already suffering from the effects of recession.—HELMUT L. KARCHER, medical writer, Munich

British MPs plan visit to Oregon

British MPs who keep watch on the NHS plan to visit Oregon next month to study ways of providing universal health care. The Oregon programme, begun in February, aims to extend a minimum range of nearly 600 health treatments to all the state's citizens. In London the all party Commons health committee, which is midway through an examination of how priorities are set in the NHS, wants to know what can be learnt from Oregon. The 11 MPs plan a five day visit in May, subject to the Labour opposition lifting a ban that it has imposed on its MPs during its current bout of non-cooperation with the government.

Conservative MP Marion Roe, who chairs the select committee, said: "We are looking at purchasing and priorities in the NHS, and we want to see how other people go about setting priorities in health care. We feel that Oregon is the only place at the moment that has a system which is up and running. It is important to go in the early stages to see how the difficulties are being met. We want to see the thing as it really is and come back and assess the implications and compare that type of system with our own."

In Oregon the MPs will ask to meet doctors, patients, and those who do the purchasing to discover what criteria are used and how they might apply to the NHS. Mrs Roe added: "It does not mean to say we are going to come back with ideas that Oregon's system would be suitable in the UK, but as a select committee we want to look at the total picture."

The health committee has completed the first stage of its inquiry into priorities, covering the NHS drugs budget, and will report soon. It is not taking evidence from health authorities on how they purchase health care for their populations.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Focus: Washington

Enthoven criticises Clinton's health care reforms

An eighteenth century measure intended to prevent the British from seizing American colonists' property has returned to haunt President Clinton's attempts to reform the US health care system.

The measure is the clause in the fifth amendment saying "Nor shall private property be taken for public use without just compensation." And it is being wielded by an unlikely opponent.

Alain Enthoven, architect of British and American health reforms, is claiming that Clinton's proposals for global budgeting are unconstitutional. The argument is a complicated one—but Enthoven's main complaint is that Clinton has moved from the idea of a managed market place to government regulation.

Enthoven, professor of public and private management at Stanford University, California, can claim the credit for providing the blueprints for two major reforms of health care. His ideas provided the rough sketches that Mrs Thatcher turned into the "new National Health Service" in Britain. And a two part paper he helped to write for the *New England Journal of Medicine* in 1989 became the foundation for the "managed competition" that runs as a consistent theme through the health reform that Mr Clinton has sent off to congress.

But Mr Clinton's architect now thinks that

his blueprint has already been changed so much as to be the basis of a whole new creation. Enthoven praises Clinton for remaining adamant about reforming the medical system, especially about widening access to care and cutting inefficiency. But in recent articles and in discussion with the *BMJ* last week he said there was one major problem in the president's plan.

Clinton wants to cut medical inflation to 1.5% a year by 1996, even though US medical inflation has been running at 4.6% a year (even Canada's rate is 3.5%). If the marketplace doesn't meet that goal Clinton would mandate global budgets set by the federal government. To Enthoven, an economist, almost nothing could be worse. Firstly, "controls reward the fat and punish the lean," he wrote recently in *Health Affairs*. In essence when politicians try to limit costs, spenders (doctors, for example) try to spend up to the limit and they avoid controlling costs and pursuing efficiency. "Eventually," he wrote, "doctors will engage in shroud waving, as in Britain and Canada: 'We have people dying because there is no room in the ICU.'" He and others have cited the inefficient Veterans Administration hospital system as an example of what happens to US health care under global budgets.

The other drawback of global budgeting, even when done through huge alliances of consumers and providers, is that it is unconstitutional. "Under the fifth amendment regulated industries must receive a fair rate of return, which in practice means cost reimbursement—which is inflationary," said

Enthoven. He pointed to other government regulated agencies, such as electrical utilities, as proof. In fact, he says, the government short circuits the market by not allowing inefficient competitors to go bankrupt: it preserves the inefficient.

On this point Enthoven contrasts the US reform plan with the new NHS. "Both plans share the belief that market forces are what best motivate innovation to improve quality, service, and to cut costs so that more services can be afforded." But ironically, even though the NHS came from a "socialised" system and the US one from private enterprise they are heading in opposite directions: Britain towards privatisation and the US towards regulation.

"In fact," said Enthoven, "I can imagine general practitioner fundholders forming larger partnerships, covering more people (for example, several hundred thousand) and gradually accepting capitation payments for an expanded range of services." That is an idea close to his own concept for US health cooperatives, which Mr Clinton has expanded into his controversial "health alliances."

"One day," said Enthoven, "I will go back to Britain and propose to call [these expanded fundholders] health maintenance organisations... I hope someone will invite me over to explain 'managed competition': the set of rules under which they should compete best to serve the public interest." Not content with seeking to preserve the essentials of his US blueprint, the health care architect also wants to update his British draft.—JOHN ROBERTS