Europe backs new declaration on patients' rights

Thirty six European nations have unanimously endorsed a common framework of principles for promoting patients' rights. The Declaration on the Promotion of Patients' Rights in Europe comes out of a consultation held in Amsterdam by the World Health Organisation's Europe office. Representatives from two patients' groups from Britain voted for the declaration, although a Department of Health spokesperson said later: "We will wait for the WHO report, then consider it."

The endorsed principles draw heavily on recent legislation in the Netherlands and in some details surpass those in Britain's patient's charter. Included are such rights as the deletion and correction of inaccurate or ambiguous medical records; the right to be chosen for treatment on the basis of medical criteria, and the right to be informed with a minimum of "unfamiliar technical terminology." The declaration is not legally binding but it is intended to have a "moral authority" which will "stimulate governments" to act.

The authors of the declaration believe it will be a powerful tool for governments and consumer groups, especially in eastern Europe and the former Soviet Union, where economic decline is threatening health services and jeopardising patients' rights. Russia has already used the text of the declaration as the first draft of a patients' rights law. Bulgaria and the Baltic states have also shown interest.

WHO adviser Professor Henk Leenen, a former professor of health law at Amsterdam university, who played a large part in drafting the declaration, said: "The purpose is to give more attention to patients' rights and to stimulate governments to do something." Although it will be left for each country to implement the declaration according to its own laws, economy, and culture, Professor Leenen believes it will have a "very high moral status."

The WHO will be sending the declaration to the "highest authorities" in the Council of Europe and the European Union. The WHO office in Copenhagen is to inform all European governments and monitor their progress, reporting to a conference in Vienna in 1996.

The declaration covers all aspects of patients' rights to informed consent, privacy, and treatment. Patients must be fully informed of the risks and benefits of different procedures, have the possibility of a second opinion, have their culture and religion respected, have a written summary of diag-

The WHO wants all patients to be informed with a minimum of "unfamiliar technical terminology"

ULRIKE/PREUSS

nosis and treatment on discharge, and know the identity and professional status of providers.

Information should be withheld only if it could cause serious harm without benefits or where the patient has made an explicit request not to be informed. A patient has the right to refuse or stop medical treatment, and all patient information, including identifiable data from human substances, should be confidential even after death.

The impact on epidemiological research of keeping patient information confidential after death was the subject of a "long debate" prior to the consultation.

A solution was agreed similar to that proposed by the Dutch patients' rights law whereby patients' files are guaranteed anonymity by being held by a third party independent of research. Epidemiologists could only get access to the information by a code number which would maintain the confidentiality of the patient.—TONY SHELDON, freelance journalist, the Netherlands

Trust audit highlights variations in performance

There are widespread discrepancies in the performance of both community services and hospitals in England and Wales, according to an Audit Commission report, *Trusting in the Future*. The commission says that clinical productivity varies by up to 50% between similar providers, with much of this variation resulting directly from the way in which services are organised and managed.

The commission says that the aim of the report is to help the managers of new trusts—many of which were being set up while the study was undertaken—to develop ways of improving performance. It says that trust status offers providers more freedom to tackle the underlying problems, and it urges managers to take advantage of this freedom.

From 1 April NHS trusts became respon-

Headlines

Aggressive campaign cuts Californian tobacco sales: An aggressive anti-smoking campaign in California has helped to cut \$1.6bn (£1bn) from cigarette sales in five years. Consumption has gone down by 1.1 billion packets (27%). Teenagers were the only group in which smoking did not decline.

France's hidden tobacco advertisements: The French press carried about Fr53m (£6.2m) worth of hidden tobacco advertisements in violation of legislation that banned such advertising. In most cases the advertisements were for products such as Camel boots, Marlboro Classic clothing, or Peter Stuyvesant Travel.

WHO acts to combat cholera in Somalia: A World Health Organisation task force has gone to Somalia to help coordinate the fight against a cholera epidemic. About 1500 cases have been reported, including 100 deaths. The main sources of infection are faecally contaminated drinking water and contaminated food prepared by infected people.

NHS trusts fail to meet targets: Nearly half of first wave trusts failed to meet the government's target of earning a real return on capital of at least 6%, according to the *Fourth Newchurch Guide to NHS Trusts*. Among second wave trusts, 27% failed to achieve the target. The report suggests that an increasing number of trusts will merge to prevent weaker ones going to the wall.

Bangladesh saves on drugs bill: Bangladesh was the first country to act on the World Health Organisation's essential drugs concept and implemented a national drugs policy in 1982. Within 10 years it has saved \$600m (£400m), and the proportion of drugs found to be substandard fell from 36% to 3%.

HIV may cause cancers: Researchers in San Francisco writing in *Cancer Research* say that HIV may directly cause a cancer of the immune system by inserting itself into a cell's DNA and switching on a dormant cancer gene.

Bradford Hill Medal awarded to Martin Gardner: The Bradford Hill Medal will be awarded posthumously to Dr Martin Gardner for his outstanding contributions to the application of medical statistics, especially in the study of occupational and environmental hazards.

sible for delivering approximately £17bn of health care activity—the equivalent of 7% of total government spending, according to the National Association of Health Authorities and Trusts (NAHAT). Barbara Connah, NAHAT spokeswoman, accepted that there were many new opportunities for trust managers. But she emphasised the rapid pace of change taking place and said that many trusts had already transformed parts of the health service.

Ms Connah said that one area of concern was with mergers, where there was always a danger of collusion: "Trust mergers need to be watched very carefully indeed. Trusts should be talking to purchasers. They must consider how any merger would affect the local population. Specifically, they need to consult all the local voluntary groups and bring in the community health councils too, as well as many other interested parties like self help groups."

The Audit Commission's report cites several areas where it believes that trusts can improve—for example, in their communication, making staff aware of the corporate strategy of the trust, and of how their jobs relate to its achievement. It says that trusts must have sound recruitment, training, and development programmes. Doctors must be closely linked to the management process as their decisions on patient care affect resources.

The chairman of the negotiating sub-committee of the BMA's Central Consultants and Specialists Committee, Mr Richard Marcus, who is also medical director of the Warwick NHS Trust, said that the commission's advice was fine when applied to a business: "In business you can motivate staff by having a profit. But we are so structured that having a profit is deemed unhealthy—we are simply told that we are overcharging, or that there are more economies we could make to bring our prices down."—CLAUDIA COURT, *BMJ*

Trusting in the Future: Towards an Audit Agenda for NHS Providers, is available from HMSO, price £8.50.

Australia may alter compensation scheme

Medical mistakes by Australian doctors are costing taxpayers more than \$A500m (£243m) a year, but compensation is being paid to only a couple of thousand patients, said a government report last week. In one of his last actions as federal health minister Senator Graham Richardson has proposed an overhaul of the medical compensation system after releasing the 400 page report from the Government Professional Indemnity Review. Its author, Ms Fiona Tito, found that up to 146 000 patients a year suffered from medical mistakes but that only 2000 received compensation. Medical mistakes—many of them preventable—were costing the federal government between \$A213m (£103m) and \$A536m (£260m) a year, said the report.

Australia's new health minister Dr Carmen Lawrence

The discussion paper, released at a meeting of federal and state health ministers in Perth, aims at improving the nation's health system and should result in a national health policy. It found that little was being done to cut the numbers suffering from preventable mistakes and made almost 50 recommendations to improve the system, including a statutory ceiling on compensation payments. It also said that the statute of limitations should be cut from the present seven years to three to ensure better access to compensation; children and disabled people, however, should be allowed six years to file a claim.

Other recommendations include speeding up the compensation process and reducing costs for patients, and changing the tax system to encourage those who get compensation to accept periodic payments instead of a lump sum. A key proposal concerns the ways in which doctors are covered by insurance. Research by Ms Tito shows that since 1984 some medical insurance premiums have risen by 1000%. The review says that the medical defence companies should fix their premiums according to doctors' income and not their specialty. Gynaecologists and obstetricians have been most affected by price rises, with their annual levies payable in New South Wales expected to rise from \$A20 000 (£1700) to \$A30 000 (£14 500).

Senator Richardson, who said that patients seeking compensation faced "insurmountable difficulties," resigned from the ministry of Prime Minister Paul Keating soon after the meeting of health ministers. One of the key and most powerful figures in Labor politics during the past 10 years, he said that he was leaving for health and family reasons. But Senator Richardson said that his promised boost to Aboriginal health would still go ahead. Planned improvements to funding of medical research and reforms of the Medicare health system would still proceed.

The new federal health minister is Dr Carmen Lawrence, the former premier of Western Australia, who has just entered parliament. A powerful voice in the women's movement, she is tipped as a possible future leader of the Labor party and is expected to maintain the high profile of the health portfolio.—CHRISTOPHER ZINN, Australian correspondent, the *Guardian*

Speed cameras linked to slower driving

The number of people killed or seriously injured has fallen by 41% since the installation of speed cameras in west London, according to the Department of Transport. Average driving speeds have also fallen, by 10 mph (16 km/h). In those places in London with cameras to detect violations of red lights accidents have been reduced by 58%.

Measures designed to reduce speeds are particularly worth while: a fall of 1 km/h in average speeds is estimated to prevent 5% of all injuries and 7% of all deaths, according to the Transport Research Laboratory's analysis of international data; in pedestrian accidents 85% of those hit at 40 mph (64 km/h) die compared with only 5% at 20 mph (32 km/h).

Only a high probability of being caught, however, will be an effective deterrent, so the police need the help of automatic devices such as roadside cameras. The Road Traffic Bill (passed in 1991), in which these were proposed, estimated annual costs of £20m to £60m for such technology, which would be more than offset by increased income from fines and, with a 5% drop in accidents, savings of around £300m.

There are also some much more sophisticated systems being developed that emphasise deterrence. Various European Union countries are testing different types of system.

One on site system being tested in Norway involves roadside monitoring devices that warn drivers when they are breaking the speed limit and register this only if speeding persists. Results suggest that reductions in speed achieved in this way could cut accidents by at least a quarter.

"In-vehicle systems" monitor driving behaviour continuously and warn the driver about violations that may be inferred from data on the vehicle and driver alone; sensors to detect, for instance, other vehicles may extend the possibilities. A "driver impairment monitor" (to check for alcohol and fatigue) is being tested in Britain.

Integrated systems provide interaction between the vehicle and the environment; electronic "tagging" of permanent or temporary road signs and markings send signals to the vehicle's computer, which compares actual with required driving behaviour and warns of discrepancies. In the last two types of system a violation may be registered by means of a smart card. A prototype integrated system built into a driving simulator (it will be put into a car shortly) is being tried in the Netherlands. It can detect speed violations, violations of "stop" signs and red lights, and driving by someone who has been drinking or is fatigued. Results so far in the simulator show that this can dramatically change driving behaviour.

Intelligent information systems are expected to deter dangerous and aggressive driving, and they are likely to be used first with young drivers, repeated offenders, and professional drivers. Their general use will have to address issues of privacy and legal issues.—DAPHNE GLOAG, freelance journalist, London

New tacrine hopes for Alzheimer patients in US

A 30 week study reported in the 6 April issue of *JAMA* of 663 patients at 33 outpatient centres throughout the US has opened a new chapter in the evaluation of tacrine (tetrahydroaminoacridine; Cognex). The study was led by the manufacturer of the drug, Parke-Davis Pharmaceutical Research Division of Warner-Lambert Company. Last September the Food and Drug Administration (FDA) approved the use of tacrine, a long acting anticholinesterase, in Alzheimer's disease.

The study was to determine the effects of high dose (up to 160 mg/day) tacrine in patients with a probable diagnosis of Alzheimer's disease with the presence of symptoms for at least one year. Because the drug was found to be ineffective in severe Alzheimer's disease, the patients in the study were categorised as mild to moderate cases. The study recorded significant improvements on several outcome measures. For example, at week 30, 42% of patients receiving 160 mg/day of tacrine were rated improved compared with 18% of patients given placebo.

An editorial in the same issue of *JAMA* stated: "Overall, tacrine improved patients' cognitive function by an amount equivalent to the deterioration that occurs over 6 months of the disease." The journal reports that the two main side effects were hepatotoxicity and dose related cholinergic effects such as nausea, vomiting, anorexia, dyspepsia, and diarrhoea.

Dr Stephen Gracon, one of the investigators, said that tacrine's benefits are strongly related to dosage. The effects of treatment with 80 mg/day could be shown, but improvement was greater when patients tolerated 160 mg/day. Dr Gracon thought that six months was the minimum period of treatment required. Asked about the *BMJ*'s editorial (7 April, p 868) entitled "Tetrahydroaminoacridine and Alzheimer's disease: for the few, but we don't know which few," he said, "Not so few, based on the higher dosage."

The rise in alanine aminotransferase activity, said Dr Gracon, is reversible and not dose related. Many patients can resume tacrine treatment after temporary cessation, maintain treatment, and move to higher dosage.

Liver biopsies have shown that the pathological changes are acute cellular changes. Patients receiving treatment for as long as two years have not shown permanent liver damage. The dose related cholinergic effects of tacrine are manageable by dividing doses and giving the drug with food. Dr Gracon said, "In reality many more will be able to take tacrine with proper treatment."

Dr Barry Reisberg, professor of psychiatry and clinical director of the Ageing and Dementia Research Centre at New York University School of Medicine, said that the work with tacrine needs to be placed in context. Doctors have been using drugs to treat the behavioural symptoms of Alz-

A camera picks up a near miss accident after a car ignored a red light

heimer's disease. The advent of tacrine has given doctors a new drug for the treatment of cognitive as well as behavioural symptoms. The effects seem to be modest and temporary. Dr Reisberg said, "We still do not have a medication effective in treating the underlying disease process of Alzheimer's disease over the long term. However, tacrine increases our armamentarium in treating with neurochemical disturbances in Alzheimer's disease."—FRED B CHARATAN, freelance journalist, Florida

Child sugar cane cutters exploited in Brazil

Sixty thousand children aged between 7 and 13 work in the sugar cane fields of the Zona da Mata in the north east of Brazil. Just under half of them work over 44 hours a week, and nearly two thirds have suffered accidents, often with the heavy scythes.

A local research institute, the Centro Josue de Castro, with money from the Save the Children Fund, has just carried out the most thorough survey ever of the conditions of the child cane cutters. Nearly half of the children are not paid for their work; they cut cane to help their parents reach the tonnage needed to earn a starvation salary. Average life expectancy in the Zona da Mata, the most fertile agricultural area in the region, is only 46 years—17 below the Brazilian average.

By drawing attention to this dangerous occupation the researchers say that they hope to provoke changes in the law to improve their conditions. Teresa Cristina Araujo, a sociologist who coordinated the survey, said: "Without the children's contributions the families do not earn enough to survive. The problem is the extreme poverty of the families. They are not broken families either—only 6% were without a father, compared with 25% in urban areas. The unions have tried to improve things, but they are limited by this fact—the families need the children's work to survive."

The survey found that though many of the children have spent some time at school, 60% of them could not read or write because they had to leave at harvest time to work in the fields. When they had accidents they were not sent to hospital but treated at the sugar cane mill. Some of them have lost the use of a limb because of inadequate treatment. "The accidents go unregistered in company clinics, in the unions, in the hospitals, and in the social security offices," says the survey.

The children, like the adults, are subject to the arbitrary decisions of the inspector when the cane they have cut is weighed. The accounting method used is so complicated that even an economist consulted by the researchers could not understand it.

The research coordinator said that the sugar cane fields are owned by politically powerful families and companies who have resisted all attempts to modernise their workers' conditions. A lot of the sugar goes for export to the markets of industrialised countries. The industry is heavily subsidised by the government, but the workers get none

of the benefits. The plantations' owners do not even let the workers plant vegetable gardens because every available bit of soil must be given over to sugar.—JAN ROCHA, *Guardian* correspondent, Sao Paulo

Denmark's hospitals suffer staff shortages

Hospitals in Denmark are having to close beds or cancel operations because of a shortage of nurses, who are taking time off to look after their children or to study under a popular new scheme. The situation is complicated by the fact that they have to give only one month's notice.

Workers staying at home to look after children under the age of 9 can receive 80% of the maximum unemployment pay for six to 12 months under the scheme, which was introduced by the government in January. The government is currently led by the Social Democrats. Similar benefits apply for study leave and sabbaticals. The intention is to tackle the country's high unemployment rate—12.5%—by encouraging job rotation. The hope is that replacement workers will be hired from the dole queue.

About 25 000 people—or 1% of the workforce—had been expected to use the scheme in the first year, but its success has already far outstripped expectations. Almost 35 000 applications had been processed by the end of March. Most came from women: more than 27 000 people wanted parental leave.

Nursing has been one of the occupations most affected, with almost 2000 of Denmark's 49 000 nurses now on leave. The crunch has come over finding suitable replacements, and the resulting shortage of nurses has hit intensive care and surgical units particularly hard. For example, one quarter of the beds in the intensive care unit in Denmark's third largest city, Odense, have been shut. More than one third of its 69 staff are missing: 14 nurses have taken leave, and 13 jobs are unfilled.

Nurses in the neurology department of a leading hospital in Copenhagen, Bispebjerg, are all threatening to resign by May, when they expect conditions to be unbearable with more than half their number on leave. The hospital is one of many trying to plug the gap by recruiting more nurses from Sweden, where there is high unemployment and pay is lower than that in Denmark.

The Danish Nurses' Council says that the leave scheme has exacerbated an existing shortage of qualified nurses. Both the Danish hospital employers' association and the Conservative and Liberal opposition have been lobbying for nursing and other essential services—such as firefighting—to be made exempt from the scheme.

So far, only a few doctors have taken leave. Possible reasons may be that, because of their higher pay, they stand to lose more financially and they find it harder to take time off and complete their hospital training.—MARGARET DOLLEY, freelance journalist, Copenhagen

Life is far from sweet for young sugar cane workers

Suicide among farmers provokes government action

The high rate of suicide among farmers in Britain has prompted the Department of Health to fund an investigation into stress in rural areas. Farmers are nearly twice as likely to kill themselves as the average person, and figures from the Office of Population Censuses and Surveys show that farming has the fourth highest suicide rate of all occupations. Only vets, pharmacists, and dentists have higher rates.

According to the Samaritans, suicide is the second most common cause of death among farmers—accidents are the first. "We have been concerned about farmers for some time and have formed rural initiatives with groups such as the Farmers' Union and Citizens' Advice Bureau to offer practical and emotional support," said Di Stubbs, national outreach organiser for the Samaritans. "Our own records are minimal and much of our evidence is anecdotal, but our helplines are being increasingly used by farmers."

John Ford, a spokesman for the Farmers' Union, said that farmers had seen their incomes fall dramatically over the past 10 years. "Although in the past year things have picked up; but farmers in the remote hills are still in financial difficulties."

Farmers are also more likely to feel stress because they are isolated. Many farms are now family concerns. The Ministry of Agriculture, Fisheries and Food estimates that 120 000 jobs have disappeared from the agricultural industry in the past 20 years. "There will now be one farmer on his combine harvester rather than 20 farm workers bringing in the harvest," said Di Stubbs. "The farmer's wife is no longer always at home—many have had to go out to work to support the farm. If the farm fails the farmer will feel that he has let down not only his children but everyone who has ever farmed that land. Farmers also have the means to kill themselves. Firearms feature in 39% of suicides."

Between 1979 and 1990, according to data from the Office of Population Censuses and Surveys, 526 farmers committed suicide. The Farmers' Union estimates that there are over 100 000 farmers in Britain. "But so many more suicides are recorded as farm accidents," said Di Stubbs. "Coroners want to be sure before they deprive families of insurance policies."

The research, funded by the Department of Health, is being undertaken by Dr Keith Hawton and Dr Aslög Malmberg, psychiatrists at Oxford University. They are interviewing relatives and close friends of 50 farmers who killed themselves and examining the circumstances and motives behind their suicides.

Dr John Wynn-Jones, a general practitioner in Montgomery in Wales and medical adviser to *The Archers*, an agricultural soap opera on BBC Radio 4, said that suicides were the tip of the iceberg of the stresses of rural life.

Between 1979 and 1990 over 520 farmers committed suicide, often because of feelings of isolation

"This is an environment where people do not share their problems," he said. "For farmers their farm is their life. They live and work on their farm. It's common for them to go 20 years without having a holiday."

LUISA DILLNER, *BMJ*

Hospital chief resigns after phone tapping

A consultant in an NHS trust hospital has taken early retirement after discovering that the trust's chief executive tapped his telephone. Dr John Spencer, consultant radiologist at Luton and Dunstable Hospital NHS Trust, has signed an agreement not to speak publicly about the circumstances surrounding his retirement.

The chief executive, Mrs Averil Dongworth, eventually resigned after consultants at the hospital passed a motion of no confidence in her. The vote was 46 for and one against.

Luton police have passed a file on the tapping to the Crown Prosecution Service. They are still waiting to hear the service's opinion on whether the Interception Communications Act 1985 was contravened in this case. If the police want to tap someone's phone, they have to seek the permission of the Home Secretary.

According to a detailed article in the *Guardian* on 1 April, Dr Spencer discovered an extra wire leading from his telephone socket on his return from holiday in February. The report says: "Later the same day, he visited the lavatory that adjoined his office. His eye was caught by a section of ducting . . . which had not been there before he went away on holiday. The panelling that covered it was held in place by just two screws and when he could deduce no obvious

purpose for it, curiosity took over. Removing the panel, he found a tape recorder seated on a small ledge. He experimented and found that the tape machine began running when he picked up his phone."

He immediately rang John Deval, an industrial relations officer with the British Medical Association. Mr Deval says: "We advised him to call the police rather than the management because we concluded that there was a strong likelihood that it was management who had planted the equipment. We were astonished that such a thing had happened."

Within a few hours, Mrs Dongworth rang Dr Spencer at home and told him that he was suspended. A statement issued by the trust on 5 March said that Mrs Dongworth had started an inquiry into "possible misconduct" by a consultant some weeks ago. "On legal advice, she agreed that a temporary listening device should be fitted to the consultant's telephone in the hospital." The statement said that when David Young, the chairman of the trust, heard of this action, he had admonished the chief executive and suspended her and one other director. "A new protocol has been established which means that telephones will not be tapped by the hospital management under any circumstances in the future."

There was no evidence of misconduct by Dr Spencer, who had decided to take early retirement, the statement added. He, the chief executive, and the other director had since been reinstated, the statement said.

Mrs Dongworth, in a statement by the trust issued on 8 March, said she believed that she was acting in the interests of the hospital in carrying out the investigation, but she accepted that the legal advice she was given to tap the telephone had been poor. On 12 March she resigned.

Kumar Sandy, full time regional officer with the union Unison, said that he believed Dr Spencer had come under scrutiny for his articulate opposition to some of the changes

Mrs Dongworth had wanted to implement. "He spoke up for what he thought was good for the hospital and for patients," he said. Mr Sandy said that morale at the trust was "very, very low" as a result of the "Rambo-style management" that staff had experienced.

A spokesman for Luton and Dunstable Hospital NHS Trust said that Mrs Dongworth had sought career advice from North West Thames Regional Health Authority since resigning. He said: "It is not for the region to find her a job, but she has been in the service for over 20 years and she has wide experience and some acknowledged skills. So we are not averse to trying to help her if we can."

David Benn, director of the London based company Lorraine Electronics, which sells surveillance equipment, told the *Guardian* that he had supplied "several" covert listening devices to NHS hospitals. He told the *BMJ* that in some cases these had been used to gather evidence in cases where drugs had been misappropriated. "No one has ever given us a reason for surveillance that is less than ethical," he said.—SHARON KINGMAN, freelance journalist, London

French government issues guidelines on prescriptions

The French government has published guidelines for prescribing aimed at ensuring that doctors do not systematically overprescribe or overtest; they could now be fined for doing so.

The guidelines, agreed by the French social security department and several medical unions, cover 15 major categories of prescribing, with several guidelines for each. For example they state that second and third generation cephalosporins should not be used as a first line of treatment.

Other areas covered include the treatment of hypercholesterolaemia; the use of endoscopy; diagnosis and treatment of non-insulin dependent diabetes; use of mammography in screening for breast cancer; treatment of essential hypertension; and antenatal and preoperative tests. Further guidelines are still being drawn up.

The government and the major medical unions have now agreed that a doctor should enter on each prescription a coded letter to indicate whether the prescription does or does not comply with the guidelines.

The French minister delegate for health, Dr Philippe Douste-Blazy, emphasised that doctors retain complete freedom of prescription and do not have to follow a guideline if they feel it is not applicable to a particular patient. It is only if a doctor consistently ignores the guidance that he may be fined. Dr Douste-Blazy said: "There are nevertheless some constant principles. We are the first to undertake such a process of medical control of health insurance expenditures, not through an accounting procedure, but scientifically."

Some medical unions have not yet signed the convention, and balk at the idea of doctors having to check each prescription against the corresponding reference to indicate whether or not it is within the limits, but this does not seem to be a major obstacle. The effects of the guidelines will be evaluated in six months.—ALEXANDER DOROZYNSKI, medical journalist, Paris

Focus: Edinburgh

The media: help or hindrance to medicine?

Opinion polls continue to rate doctors right at the top in the eyes of the public, way above estate agents and car salesmen and also above journalists. But how much does the medical profession owe to the media in

maintaining this position and how have relations between the two changed? While agreeing that newspapers, television, and the radio now played a much greater role in reporting medical stories, speakers at the recent meeting of the BMA's Junior Members Forum in Edinburgh had different answers influenced by their jobs or personal experience.

Some doctors now feel that they are being tried by the media and with health considered more as a commodity more medical decisions are being questioned. This is the view of Dr Jonathan Gabe, a senior research fellow at Royal Holloway University, London. The patient's charter has encouraged more people to complain and litigation has increased. He doesn't think that doctors can be complacent with their high ranking in the polls as the health service goes through a period of change. He used examples from television programmes to show the different ways in which medical matters are now portrayed. Gone are the "doctor knows best" programmes of the 1950s and 1960s. As patients and pressure groups become more influential doctors are seen in a less romantic light. Documentaries show doctors in con-

frontation with their managers and exposés criticise doctors' actions using heavyweight journalists or the foot in the door technique.

Dr Marietta Higgs had three years' experience of coping with exposure in the media when criticism of the way that she and a colleague dealt with signs of child sexual abuse led to the Butler-Sloss inquiry in Cleveland. She then had a battle in the high court to rescue her employment. Now a consultant paediatrician in Gateshead, Dr Higgs said she knew it was time to call a lawyer when she saw "Sack Them" blazoned across a newspaper headline. She found it difficult to condone headlines such as "the first child is set free" to report a hospital discharge.

Although for much of the time Dr Higgs was unable to comment publicly in response to misleading reports her advice to doctors who find themselves in a similar position is to find a journalist they can trust. A live interview in which the message is kept simple is the best way to get the facts across. One positive outcome of her story, Dr Higgs believes, is that more abused children are now being believed.

Journalists are also subject to headline abuse and Mr Chris Holme, who writes for the *Herald* newspaper in Glasgow has had medical stories distorted by subeditors' pens. He thinks that doctors do have a good press and that medicine in general is well served by the media even by the tabloids. Read by millions, Holme believes that they have done a good job in promoting health through better diet, more exercise, and quitting

smoking even though this means that they run the risk of alienating at least half their readership. If as Gabe suggested, however, a more resentful and litigious public turns antidoctor then Mr Holme warns that there are dangerous times ahead.

One of Mr Nigel Duncan's tasks is to try to prevent this and to help Mr Gabe and his colleagues get their facts right by pointing them to the right experts and explaining the BMA's and doctors' views. Dr Higgs was forced to say "no comment" on many occasions, but the head of the BMA's public affairs division said that normally doctors cannot afford to ignore the press. If the BMA declines to comment other organisations or health professionals will step in. Mr Duncan has to sustain a high public profile for the association. It has used the media for many years to influence public opinion—for example, to legislate for the wearing of seatbelts, to reduce junior doctors' hours of work, and to try to ban tobacco advertising and boxing. And Mr Duncan will use the media in the forthcoming campaign which the BMA and the Department of Health are organising to persuade people not to call their general practitioners out at night.

No one mentioned the importance of trying to influence MPs until Mr Duncan was asked about the BMA's campaign against the NHS reforms at the end of the 1980s. He had not been involved but he thought that although the campaign had achieved its aim of winning over public opinion, more attention should have been given to a parliamentary campaign.—LINDA BEECHAM, *BMJ*