France approves bill to encourage organ donations

The French National Assembly has approved a bill that would allow doctors to remove organs from dead patients unless they had expressed specific opposition to organ donation. The opposition would be recorded on a national register so that doctors could find out through a computer system whether they could remove a particular organ.

Transplant specialists hope that the legislation will reverse the sharp fall in organs available for transplantation. The number of transplants grew steadily in the 1980s, reaching a peak of 3572 in 1991. Since then it has been decreasing: 3220 in 1992 and 3180 last year, when 195 people on waiting lists for a heart, lung, liver, or kidney transplant died before an organ was available. Statistics for the first three months of this year are even more worrying: the number of available organs has decreased by more than a third in comparison with the same period last year.

According to heart surgeon Christian Cabrol, president of France-Transplant, the private non-profit organisation that manages transplantations, an increasing number of families refuse to let doctors take organs from their relatives. Last year French specialists took 3408 organs after the death of 977 patients, but 412 potentially usable organs were not collected because relatives objected.

Professor Henri Kreis, head of transplantation at the Necker Hospital in Paris, said that the situation was critical to the point of threatening the transplantation programme. "We can imagine that if our society refuses organ donation it does not wish to benefit from transplantation," he said. Kreis wonders whether organ transplantation may become a marginal technique benefiting only a few privileged people with living relatives willing to donate an organ.

Growing reluctance to donate organs has been linked to a series of publicised incidents, starting with the unauthorised removal of a dead boy's eyes two years ago, and continuing last year with reports by the inspectorate general of health of irregularities in the collection of organs. The inspectorate noted the disproportionate number of non-resident foreigners, particularly Italians, among recipients of organs and recommended more rigorous state control.

Professor Jean Dausset, a Nobel prize laureate for his work in immunology, proposed the measure to increase the number of donors by the setting up of a computerised list of people who specify that they do not

A new law may mean more hearts are available

want to donate their organs after death. The national ethics committee has not yet approved it. The national assembly discussed the proposed legislation as part of a sweeping bioethics bill and the text was modified to include guarantees that the certification of brain death is not interfered with in any way. —ALEXANDER DOROZYNSKI, medical journalist, Paris

Dutch prosecutors get tough on euthanasia

Evidence is emerging of a tougher prosecution policy against Dutch doctors who perform euthanasia in the aftermath of last November's law on euthanasia. The law left euthanasia a criminal act punishable by 12 years' imprisonment and made doctors legally obliged to report their actions. Yet the effect of the law was to permit euthanasia if it was carried out within strict guidelines.

Since the law was implemented last November there has been a sharp increase in the number of doctors being investigated. Local prosecutors are now inquiring into 14

cases of euthanasia in 1993. By comparison, four cases were investigated in 1992 and one in 1991.

In 12 of the current 14 cases the patient was not terminally ill—which suggests that the lack of a "terminal phase" in euthanasia has been singled out by prosecutors. Yet in almost identical cases in previous years local prosecutors did not proceed against doctors. Guidelines published by the Dutch Royal Medical Association (KNMG) and confirmed in court decisions do not require that the patient is terminally ill but that he or she has an "unacceptable and hopeless suffering."

Justice Minister Hirsch Ballin, who promised an "active prosecution policy" during the parliamentary debate on the law, met with the five senior prosecutors in the Netherlands and discussed outstanding cases of euthanasia eight days after the act was passed. Ballin has denied that the prosecution policy has been sharpened up and says that there is a log jam of investigations that were held up during the year long debate over the law.

Johan Legemaate, a lawyer for the KNMG, said that the association was getting an increased number of telephone calls from doctors who thought that the policy of local prosecutors was getting "tighter." Doctors

Headlines

WHO changes its strategy: The World Health Organisation believes that the decrease in living standards in the poorest countries since 1980 will make a nonsense of the United Nations' target of "health for all by the year 2000." The WHO has therefore singled out inequality as the real cause of malnutrition and disease in the Third World.

Consumers find evidence of fast tracking: The Association of Community Health Councils in Britain says that it has found "strong evidence" of a two tier hospital system with fast tracking for patients of fundholding general practitioners. The practice was extensive and deliberate, with hospitals giving priority to patients whose condition was clinically urgent or who were fundholders' patients.

Charter for maternity services lists standards for care: A patient's charter for maternity services in Britain, launched by the government last week, states that women have the choice to give birth at home or in hospital, and that they should have a named midwife responsible for their care and be seen within 30 minutes in antenatal clinics.

WHO launches rabies offensive: The World Health Organisation is launching a campaign in 10 European countries to eradicate rabies over an area of 300 000 km. An oral vaccine is being distributed to foxes in baits, and if successful rabies could be eliminated within the next few years in Austria, Belgium, the Czech Republic, France, Germany, Italy, Poland, Slovakia, Slovenia, and Switzerland.

Germans are the leading alcohol consumers: Germans have succeeded the French as the world's leading alcohol consumers, according to the German Federal Health Office. Germans drink more than 140 litres of beer each every year, about 27 litres of wine and champagne, and 10 litres of other alcoholic beverages.

Study of cancer link with nuclear work abandoned: The UK Medical Research Council has abandoned research which showed a link between fathers working in the nuclear industry and leukaemia in their children. A link was first highlighted four years ago in the *BMJ* by the late Professor Martin Gardner of the University of Southampton. Subsequent studies have been unable to substantiate his findings.

were calling partly in anger after they were investigated for acts of euthanasia that some years ago would have been ignored. "There is much more scrutiny than doctors would have expected. The strong impression here is that the trend is continuing."

The prosecutors seem to be looking at cases of euthanasia in which the patient was not terminally ill and the patient's regular doctor was not involved. Both issues are part of the case concerning psychiatrist Dr Boudewijn Chabot, which has been dismissed by a local prosecutor and appeal court. The justice ministry is now seeking a legal judgment on the case in the High Court on 24 May. Yet the Dutch attorney general, Leo Meijers, in his advice to the court said that a terminal phase in the patient's condition was not absolutely necessary to justify euthanasia.

Johan Legemaate believed that Justice Minister Hirsch Ballin seemed to be having second thoughts about euthanasia even though the law had been passed by a coalition of votes with the Labour party on the understanding that current practice of euthanasia would not be restricted.

In a parliamentary debate last week Jacob Kohnstamm, a member of parliament for the centre party Democraten 66, failed to win a vote against prosecuting doctors in cases of euthanasia in which the patient was not terminally ill. He said that he would try again after the general election on 3 May in order to achieve a "decent prosecuting policy," which was "too risky" to be left to local prosecutors. He is convinced that the current government policy will lead to fewer doctors reporting euthanasia.—TONY SHELDON, freelance journalist, Utrecht

Australia looks at promoting men's health

Australia's new federal health minister, Dr Carmen Lawrence, has taken over the controversial post with plans to make men's health a priority. Dr Lawrence, who in 1990 became the nation's first woman state premier and is tipped as a future prime minister, has also scotched her predecessor's proposals to introduce a higher Medicare levy for the rich.

The minister is now preparing to deliver her ideas to the country in time for the budget on 10 May, but she has already unveiled certain key policies. "One of the big problems in our society is that we pay far too little attention to men's health," she said. "If you look at the group in the community who die younger, at every age from conception to their death, men are subjected to or experience ill health and death in greater numbers than do women."

"I don't think we should overlook the fact that in our community we have tended to take for granted the fact that men have inferior health outcomes to women. It's almost as if that is what it means to be a man," she said.

Dr Lawrence, a widely respected academic and feminist, took over from Senator Graham Richardson last month after he unexpectedly decided to retire from politics. Already she has dropped Senator Richardson's plans for a two tier Medicare levy to encourage the rich to take out private health insurance. She said that the proposal was absurd and was akin to

Australian men's health will become a priority

forcing the better off to send their children to private schools.

Dr Lawrence has made early commitments to Aboriginal health and mental health funding. But she has warned that the planned increases in medical research and breast cancer screening will not be great.

The minister's first meeting with the Australian Medical Association, which traditionally has had an often fiery relationship with the Labor party incumbents, was considered a success by both sides. Dr Lawrence said that Dr Brendan Nelson, the association's new president, was "committed and progressive." And she expressed delight that their first talks involved issues other than doctors' incomes.

Dr Nelson, too, welcomed her appointment but said that he would defend the interests of the medical profession. Proposals to fix doctors' fees by placing them on contracts is an area of potential conflict.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

Chile appoints economist to sort out health service

The Chilean government has appointed an economist, Carlos Massad, as the new health minister to sort out what the public regards as a health service riddled with outdated technology, strikes, and long waiting lists. Chile's health service was grossly underfunded during General Augusto Pinochet's 17 years of military rule. When a civilian government was re-established in 1990 rapid economic growth enabled health spending to increase by 50% over four years. But opinion polls show that the public still feels that service is poor. Most of the increased expenditure went on restoring salaries and repairing crumbling hospitals. Dr Francisco Peragallo, medical director at Santiago's Salvador Hospital, said: "Higher spending has had little noticeable effect because there was so much to do."

Providing more money may be only part of the answer. There is also the difficulty of regulating the private health sector that took off during the 1980s and now treats one in four Chileans. "Essentially you are building up two types of medicine in the same environment," said Mr Jorge Katz, of the United Nations' Economic Commission of Latin America and the Caribbean. While the private sector invests in modern technology and pays good salaries public hospitals are left to provide much of the routine treatment.

High insurance premiums for elderly or chronically sick people means that most private patients return to the public sector just when their treatment becomes most expensive. Many doctors believe that Chile's poor are in effect subsidising the rich and that insurance companies should be obliged to provide special cover for old age and chronic illness.

The high standards of private sector treatment also raise expectations in the public

Chile's poor may be subsidising the rich

sector. Chileans are now demanding shorter waiting lists, modern technology, and a service that is more friendly to patients. As the novelty of democracy wears off and as living standards rise (by an average 6% a year) the public increasingly wants a health service that is comparable with that in developed countries.

Dr Julio Montt Vidal, director of Santiago's Calvo Mackenna paediatric hospital, feels that the crisis reflects the high standards that the health service has already reached, such as life expectancy and infant mortality of 72% and 17% respectively. "Our crisis is one of success. We've already solved most of our basic problems."

But that is not the public perception and the new government is moving towards decentralising decision making and resource allocation within the health service to make it more responsive to patients' demands. "Hospitals must become responsible for diagnosing and solving their own problems," said Dr Montt Vidal.

Some doctors feel that decentralisation could lead to fewer resources in poorer areas, but Dr Peragallo is more typical in his belief that greater autonomy will enable hospitals to manage their budgets more efficiently. He is a critic of the current bureaucracy in which, for example, wage cheques for medical staff in Patagonia are made out thousands of miles away in Santiago.

Carlos Massad has also promised to tighten up on non-payment of state medical contributions and to tackle the problem of cross subsidies between the private and public systems.

The fact that Mr Massad is an economist and not a doctor caused some controversy at first. But many doctors have come around to the idea. "The problems of our health sector are largely technical, financial, and administrative," said Dr Peragallo. "Having an economist in the ministry should improve the interaction between these three aspects."

DAVID PILLING, Chilean correspondent, *Financial Times*

GMC finds GPs guilty of fraud

The General Medical Council has ruled that the names of three general practitioners should be erased from the register because the doctors falsified patients' records in clinical trials. Dr Chatru Chandnani and Dr Christopher Vishin, partners in Leeds, and, in relation to a separate incident, Dr Paul Daengsvang of Liverpool were all found guilty of serious professional misconduct by the disciplinary committee. Dr Daengsvang is appealing to the judiciary committee of the Privy Council.

The GMC heard that in 1989 the Leeds partners took part in trials for three different pharmaceutical companies; one was a trial of a drug for hypertension and two were paediatric asthma trials. The contract research organisation that had commissioned the doctors grew suspicious after seeing the diary cards that the hypertensive patients had supposedly filled in. The cards were in unusually pristine condition, and in several cases the handwriting strongly resembled that of Dr Chandnani.

In one of the paediatric asthma studies Dr Chandnani recorded peak flow measurements to a degree of accuracy that was not within the sensitivity of the instrument. Again, entries on the diary cards were found in several cases to resemble his writing. Patient recruitment and attendance had all been far better for the Leeds partners than for other doctors involved in the trials. The trial materials returned by the two doctors showed no signs of wear and tear. Scatter plots of blood pressure readings were also more consistent than in those of other investigators.

Blood samples taken by the doctors were

assayed and found to be completely lacking in the drug or its metabolites, proving conclusively that the patients had not taken the product. Documents were later found that showed that some of the patients had not been involved in the trial at all. The contract research company referred them to the GMC.

The hearing was told that Dr Daengsvang was recruited in summer 1990 by a pharmaceutical company, Cilag Limited, to test a product for the treatment of perennial allergic rhinoconjunctivitis. Patients were required to fill in diary cards and give blood samples for haematological and biochemical tests.

Dr Daengsvang, who had done satisfactory research for the company before, was asked to recruit 15 patients, which he did so quickly that he asked for, and was granted, facilities to recruit 10 more. He shortly had a total of 20 patients. When the company collected the records and residual material from the trial in February 1991 suspicions were aroused by the pristine condition of the diaries and the "perfection" of the study data. Dr Daengsvang's results were compared with those produced by other study centres.

The company then sent Dr Daengsvang's consent forms and patients' diaries to a handwriting expert at the Division of Questioned Documents of the Laboratory of the Government Chemist. His conclusion was that at least 16 of the diaries seemed to have been written by Dr Daengsvang and that they had not been filled in on a daily basis.

Examination of the NHS records showed that one patient's date of birth had been altered from 1914 to 1974. Dr Daengsvang was also found to have taken blood samples from patients other than those supposedly entered in the study, thus requiring them to have unnecessary blood tests.—OWEN DYER, freelance journalist, London

New medical bill could tackle education

Legislation to protect patients in Britain from doctors who perform badly is likely to be shelved for another year. Instead of a bill being introduced this autumn, the NHS Executive now gives October 1995 as the target date for amending the 1983 Medical Act. The amendments will give the General Medical Council (GMC) statutory powers to deal with incompetent doctors whose performance does not amount to serious professional misconduct.

But the planned new bill will go beyond the original GMC proposals. It will also implement changes in medical education and training. The government is likely to produce a white paper after a period of consultation on what the executive describes as "a comprehensive strategy for medical education, training, and regulation." This will produce an intensive debate on medical education in the first half of next year.

The delay to the Medical Bill is indicated in the NHS business plan for 1994-5, issued last week. The amending bill was expected in the next parliamentary session, having failed last year to be included in the current legislative programme. The business plan leaves the timing slightly ambiguous by stating the objective "to prepare and manage the passage" of a bill by October 1995. Priority in the 1994-5 legislative timetable is given instead to a bill restructuring the NHS in England by abolishing regional health authorities and enabling family health services authorities to merge with districts.

If the bill on doctors' performance is delayed until 1995, with implementation the following year, it will have taken at least six years to prepare and enact.

There is also pressure for an overhaul of medical education. The GMC last year issued proposals for removing the factual overload from the student curriculum and making space for subjects such as communication skills, audit and management, scientific methods, and medical ethics. But the GMC has at present no powers to make medical schools adopt its recommendations.

The approach to legislation is also affected by the breakdown of the former political consensus on regulating the medical profession. The Labour party has hinted at an end to self regulation through the GMC in favour of an independent body.

Last week's NHS business plan sets out more than 80 corporate objectives to improve the health of the nation, ensure high quality care, and secure value for money. A long term action plan is to be developed for "clinical effectiveness," indicating which treatments are to be preferred. This is to be ready for the 1995-6 contracting round to enable purchasers to write protocols into contracts. Other projects will aim at fundamental change in the general medical services, affecting general practitioner prescribing, out of hours service, and pay.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Dr Christopher Vishin and Dr Chatru Chandnani have had their names erased from the register

NATIONAL PICTURES

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Industry must be more involved with the genome project

Report calls for collaboration on genome research

The British human genome mapping project has enormous potential for the improvement of health and wealth creation, according to a report from the Advisory Committee on Human Genome Research. "We predict that the increased knowledge of basic biology will eventually transform medical practice," say the authors. The report was commissioned under the auspices of the Office of Science and Technology. The independent group of geneticists behind the report was chaired by Professor Kay Davies, who said: "It is vital that we nurture the partnership between government departments, academia and industry to maintain the competitive position of the UK in this field into the 21st century."

Not everyone is quite so enthusiastic as the authors are about the eventual impact of the research. Steven Rose, professor of biology with the Open University, is concerned that the advocates of human genome therapy in general have been "guilty of extraordinary hype." He said: "They are calling it things like the book of life, or the code of codes, implying that if you actually trace the whole sequence of the genome then you can predict everything about the organism. The research is of course valuable, but it is not the answer to the whole human condition. Let's face it, most deaths are not tied up to specific genetically related conditions."

Among the key recommendations in the new report are that industry should become more involved with the human genome mapping project and that more widespread

use should be made of existing genetic resources in industry, charities, and academia. As far as genetic mapping is concerned, the report recommends that "priority should be given to the collection of family material in the UK. In particular, the NHS should ensure that the collection of vital information and materials from patients and families is encouraged and enhanced by local providers and purchasers."

The report, which examines the priorities and opportunities in human genome research in Britain, concludes that Britain is in a strong position to exploit its clinical base and recommends that this should form "a basis for exploitation in an international setting." It also recommends a careful review of the Data Protection Act "to ensure that such developments do not pose a serious threat to the effective exploitation of scientific results to national advantage."—CLAUDIA COURT, *BMJ*

Britain ignores UN convention on children's rights

Britain continues to ignore the rights of children despite having ratified the United Nations Convention on the Rights of the Child two years ago, says a report from the Children's Rights Development Unit. The unit, set up as a charity to audit Britain's implementation of the convention, claims that the government, which has already given its own report on its progress to the UN, is complacent and dishonest.

The convention has 54 articles that cover all aspects of children's lives, such as their right to adequate housing, to agreed standards of health care, to safety at school, and to play in safe areas. Central to the convention is article 12, which states that children should have the right to express their views about decisions that affect them and to have those views taken seriously according to their age and maturity. The report from the Children's Rights Development Unit finds that in education, health, housing, youth services, and environmental issues the voices of children have been ignored. For each article it suggests what action is needed to make Britain comply with the convention.

"The government has an obligation under international law to put the convention into practice," said Gerison Lansdown, director of the Children's Rights Development Unit. "But it is not scrutinising policy to see if it impacts on children. The reports of other countries to the UN have a sense of humility—that there is room to improve. The British report has no humility and fails to acknowledge how we can move forward. *The Health of the Nation* does not address social inequality and neither does the report to the UN—it has one and a half sides out of 130 pages on children's rights to adequate standards of living and doesn't mention that one third of children now live in families with incomes that are below half the national average."

The report argues that by refusing to ban cigarette advertising the government fails to fulfil Article 3.2 which requires that a child should have as much "protection and care as is necessary for his or her well being." Children are also entitled to a clean water supply—a right that has been eroded with the privatisation of the water supply. In 1992, 21 000 households were disconnected—a 177% increase over the previous year. The report suggests that water companies should be banned from disconnecting supplies and be asked to pursue other methods of recovering debts.

Under articles related to health the report is doubtful that children are involved in decisions about their medical care. Judgments in British courts have interpreted the law as allowing children to consent to treatment but not to refuse it—especially when a parent wants that treatment.

Doctors working in child health surveillance are given no guidance on eliciting the views of children, and the report states that children are thus "passive recipients" when they should be involved in their health care from an early age.

The UN committee will cross examine a government delegation on its implementation of the convention in January 1995. "The committee has already been critical of some countries," said Gerison Lansdown. "Russia was criticised for keeping disabled children in large institutions."

As well as trying to influence that process the Children's Rights Development Unit is working on a good practice guide based on the convention with the British Paediatric Association and the Royal College of Nursing. So far 150 health authorities and trusts have

said that they will adopt the convention and use the guide to audit their progress in providing and commissioning services for children.—LUISA DILLNER, *BMJ*

UK Agenda for Children is available from Children's Rights Development Unit, 235 Shaftesbury Avenue, London WC2H 8EL, price £20.

Challenge to accident department closure fails in court

An 80 year old woman and two London boroughs failed this week in an attempt to stop the health secretary, Virginia Bottomley, going ahead with plans to close the accident and emergency department at one of London's oldest and most famous hospitals.

Monica Willan, a former housekeeper at Harrods department store, and the London Boroughs of Hackney and Islington sought judicial review of the decision to close the accident and emergency unit at St Bartholomew's Hospital, which they claimed was "irrational and perverse." Their QC, Lord Lester, had argued that the consultation

process leading up to the closure decision was a sham and that Mrs Bottomley had prejudged the outcome and based her decision on irrelevant information.

But Lord Justice Leggatt, sitting with Mr Justice Buxton, rejected their application, saying that the secretary of state had not made up her mind in advance. The judge said that Mrs Bottomley continued to believe that the closure was "safe and sensible in all the circumstances" and ruled that her decision was not open to legal challenge.

He said "no one London born, or a lover of London" could learn without sadness or deep emotions of the decision to close any part of one of the capital's great teaching hospitals. But it was to parliament and the electorate, not the courts, that the secretary of state was answerable for an unpopular decision.

Lord Lester had submitted that Mrs Bottomley had taken her decision before the consultation process had even started and had failed to give "conscientious consideration" to the views of the public.

The decision to axe the department had its roots in the 1992 Tomlinson report, which proposed that the hospital should be merged with the Royal London Hospital at its Whitechapel site in east London. The report said that accident and emergency services for the City of London could be adequately provided by other London hospitals. The government

intends to close the unit by the end of the year. Other services at the 800 year old hospital will be moved from its Smithfield site to the Royal London Hospital except services for AIDS, oncology, and endocrinology and some services for cardiology.

Among the opponents of the move are the City of London police, whose acting commissioner wrote to Mrs Bottomley last year: "The thought of transporting casualties to the Royal London Hospital in the almost permanent traffic chaos existing between Aldgate and that hospital is too horrendous to contemplate. Apart from the logistics of dealing with the needs of persons who are taken to that hospital, I fear lives may be lost and suffering prolonged and worsened by the inability to reach with reasonable speed that or any other alternative hospital remaining after the government's plans are put into effect." The police also later expressed dismay after Mrs Bottomley announced closure plans for Guy's Hospital.

Mrs Willan, who lives near the hospital in Clerkenwell, said: "I am devastated that the battle is lost, but the war is still on. This is the thin end of the wedge and the whole hospital will be closed unless we fight on." The judges, who refused leave to appeal, ordered Mrs Willan and the two councils to pay the government's legal costs.—CLARE DYER, legal correspondent, *BMJ*

Focus: London

Subversion in the provinces

This week ministers face an acrimonious debate in parliament on London's health care. Health is always a good topic for the Labour party in opposition, and at the moment it's a particularly good issue in London. There are local government elections in early May, and the effects of the Tomlinson report continue to create waves as they work themselves through.

In the past couple of weeks, for example, there have been rows about the elderly not being treated (not just a London problem and not a new one either); the secretary of state has been challenged in the high court over her proposal to close the accident and emergency department at St Bartholomew's Hospital (the challenge failed, but an appeal is promised); and an all party group of London MPs has been formed to defend Guy's Hospital from the proposal to denude it of acute services. Meanwhile, London's general practitioners continue to complain of the failures of secondary and continuing care, and some are also becoming frustrated at the difficulty of obtaining any of the promised funding for innovations in primary care.

No wonder the health secretary, Mrs

Bottomley, is rumoured to be wanting a new job. But the opposition should tread a little warily: there isn't much sympathy for London in the rest of Britain, which has troubles of its own. As John James, chief executive of a London health authority, recognises in a lucid pair of essays on the health reforms (published as Bath University social policy papers), "It may be small comfort to [the government], as their overall unpopularity grows, that the view of most health care professionals outside London, and many within it, is that the process of change in London is... overdue."

While there may be support for its London policies, the government's more general health policies were being undermined in the provinces this week from another—and potentially subversive—direction. The British Deming Association exists to promote the work of Edward Deming, the American who taught the Japanese about continuous quality improvement after the second world war.

Last week it held a seminar in Salford to introduce the ideas to a group of NHS managers and clinicians. The ideas are rich and complex and need some explaining (and later this year the *BMJ* will publish a series on the subject), but essentially Deming's philosophy teaches that organ-

isations should be directed towards what customers need and organised to that end, that the quality of products and services is addressed by working on processes and reducing variation in them, and that organisations need to be managed to allow their workers to work collaboratively and overcome the organisational barriers that hinder them. In particular, Deming's management principles condemn several practices that seem fundamental to the new NHS: an emphasis on competition, inspection, numerical targets and quotas, performance related pay, and buying services on price alone. Not surprisingly, many of Deming's ideas went down well with a health service audience.

The NHS Executive is said to be much interested in the ideas of continuous quality improvement. It has issued a circular on improving quality, and it has invited Don Berwick, a paediatrician and one of the leading proponents of improving quality in health care in the United States, to run a seminar in June for the top of the executive. A Damascene conversion may be too much to expect, but Deming's ideas are powerful and Berwick is a convincing proponent. At the very least it should prompt some serious questions at the top of the NHS.—JANE SMITH, *BMJ*