Decisions in US say that doctors can assist suicides

Americans got three messages within three days last week that in some cases it may be legal for doctors to help patients to commit suicide. It appears, at the very least, that prosecutors will have trouble imprisoning doctors who help people die.

Most notably, a jury in Michigan acquitted Dr Jack Kevorkian, the 65 year old retired pathologist who has helped 20 seriously ill patients to end their lives. Dr Kevorkian faced charges on a law designed to stop his activities, and he was eager to face prosecution in the hope of forcing the courts to take a firm stand. "I just want to show society's insanity," he said after the jurors acquitted him after nine hours of deliberations.

The jurors were not unanimous in their reasons, but they all seemed to accept that a doctor can seek to end a patient's pain and suffering even if that treatment hastens death. The jurors agreed that when Dr Kevorkian helped a 30 year old man with motor neurone disease to inhale carbon monoxide he meant only to help end the patient's suffering.

The acquittal followed a 9 to 7 vote the day before by the Michigan Commission on Death and Dying that basically supported Dr Kevorkian's arguments. Although the vote by the group, which represented various organisations involved in the debate, was non-binding, it had been sought by the state legislature, which has until November to vote on it.

The commission would allow doctors to help adults to commit suicide if they were suffering from "terminal conditions" defined as conditions likely to result in death within six months or if they had an "irreversible suffering condition" that involved "subjectively unbearable or unacceptable suffering from a physical condition." A doctor would have to be present at the suicide but the suicide could not be carried out without the agreement of another doctor, a psychiatrist or psychologist, a social worker, and an expert in pain treatment.

Although most members voted predictably along the lines of their organisations' philosophies, there were some surprises. Perhaps the most unusual was the strong support given by John O'Hair, the attorney responsible for prosecuting Dr Kevorkian. But O'Hair pointed out that Dr Kevorkian would still have violated the limits set by the commissioners and would therefore still be subject to the same penalties of the law: up to four years in prison.

Two days after Dr Kevorkian's acquittal a

Kevorkian in court

federal judge ruled that the government cannot interfere with a person's wish to commit suicide to end suffering. US District Judge Barbara Rothstein in Seattle used a ruling on abortion made in the Supreme Court in 1992 to overturn a Washington law that bans anyone from helping in a suicide.

The nation's highest court said that while a woman's right to abortion is fundamental, states can regulate the practice "within reason." Judge Rothstein said, "Like the abortion decision, the decision of a terminally ill person to end his or her life 'involves the most intimate and personal choices a person can make in a lifetime' and constitutes a 'choice central to personal dignity and autonomy.'"

The suit was brought by five doctors and several citizens, led by Compassion in Dying, which does not give lethal drugs but refers patients to doctors who will prescribe drugs in sufficient doses to cause death. Their opponents said that patients were vulnerable to suggestions that suicide was a simple way to end suffering, while other means often existed that would prolong life.

Legal scholars are still unsure of what the acquittal of Dr Kevorkian, the Michigan commission's vote, and the US judge's decision will mean, but most agree that liberalisation of doctors' assistance in suicide is likely and that guidelines for the practice are necessary.—JOHN ROBERTS, North American editor, *BMJ*

Euthanasia remains illegal in Britain

British law will not be changed to permit euthanasia, mercy killing, or assisted suicide, but the management of patients in a persistent vegetative state and the operation of advance directives may be put into a code of practice. The government's response last week to the Lords select committee on medical ethics effectively ended the debate on euthanasia surrounding two particular cases: that of Tony Bland, who was in a persistent vegetative state after the disaster at Hillsborough football ground and whose artificial feeding was withdrawn, and that of Dr Nigel Cox, a rheumatologist who gave a lethal injection of potassium chloride.

A white paper states the government's "overriding concern" to protect the interests of patients; to ensure that health care is humane, ethical, and legal; to safeguard the patient's right to withhold consent to treatment; and to ensure that actions that have as their intention another person's death continue to be unlawful. This endorses the select committee's rejection of the case for legalising euthanasia, though the government has reservations on aspects of withholding treatment that prolongs life. The government reserves its decision on the recommendation that decisions that limit treatment should be made jointly by all

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Headlines

UK government agrees on a unified complaints system: A single complaints system for NHS patients recommended in an official report this week is to be adopted by the government. The Wilson report *Being Heard* wants more complaints settled informally, with a backup formal investigation by a panel under a lay chairman to report within five weeks.

More British patients are waiting more than a year: In the first three months of 1994, NHS hospitals in England cut the number of patients waiting over one year for operations, though the total is still 14% more than it was a year earlier. The total waiting list has risen by 7% to 1 065 349.

Indiana will not comply with abortion law: The United States state of Indiana says that it will not comply with a federal law requiring Medicaid to pay for abortions only when the mother's life is in danger.

European court will decide on free prescription issue: The European Court of Justice in Luxembourg will decide whether Britain has contravened European Union law in giving women free prescriptions from the age of 60 while making men pay until they were 65. A 64 year old British man accused the government of breaching a European directive by tying free prescriptions to pension ages.

American doctors change course on health insurance: The American Medical Association says that companies with 100 or more employees should be required to pay health insurance for workers but that smaller companies should be exempt. Many doctors are small employers, with as many as one in three not providing insurance for their staff.

Health visiting service is in crisis: The number of health visitors in England has fallen 4.5% since 1988, putting the service into crisis, according to the Health Visitors Association. The numbers in training are less than half those forecast—545 instead of 1106.

Britain may screen immigrants for tuberculosis: An interdepartmental task force set up by the British government is considering whether to screen immigrants and refugees for tuberculosis. The task force is also looking at the need for guidance on local control procedures, the impact of the disease on the homeless, and the need to review control measures in prisons.

concerned in the care of an incompetent patient.

The government has agreed to begin discussions with health professionals on a code of practice on the management of the persistent vegetative state and advance directives. Further recommendations are awaited from the English and Scottish law commissions. In addition, the NHS management has also been asked to develop strategies for palliative care.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Government Response to the Report of the Select Committee on Medical Ethics (Cm 2553) is available from HMSO bookshops, price £2.

Parliament faces paradox over advertising bans

The British government this week faced the paradox of its health ministry refusing to ban tobacco advertising on libertarian grounds and its food ministry proposing to ban advertisements for baby milk on health grounds. Both issues are before parliament simultaneously.

The Tobacco Advertising Bill was due to reach its final stages in the Commons on 13 May. Although it has overwhelming support—by 227 votes to 17 at an earlier stage—it faces the nearly insurmountable hazards of a private member's bill on a controversial topic. Passive opposition by the government and active opposition by a hostile minority of MPs are usually fatal and, barring a tactical surprise, were expected to kill off the bill.

The Department of Health is concluding

negotiations with the tobacco industry for further voluntary restraints on advertising. One of its main arguments has been that imposing a statutory ban on a product that can be sold legally would be wrong, and it is not prepared to create a precedent over tobacco.

There are fewer qualms on that score, however, at the Ministry of Agriculture, Fisheries and Food concerning infant formula. The ministry has issued draft regulations for a statutory ban on advertisements for baby milk except in publications whose readers are health care professionals. Food minister Nicholas Soames admitted in the Commons that the draft regulations go further than the European Union directive that they enforce. He said: "Given the health arguments in favour of breast feeding, we thought it right to explore the possibility of going further than the minimum required by the directive."

Under the present voluntary code of practice, advertisements for infant formulas directed at mothers and pregnant women are restricted to magazines distributed within the health care system. Mr Soames said that the European Union directive seemed to allow advertisements to be placed in baby care magazines that were generally available. When challenged on the inconsistency of the government's legislating against the advertising of infant formula while refusing to take similar action on tobacco, Mr Soames drew a distinction between cigarette smoking being a matter of personal and adult choice and seeking to protect the interests of newborn infants, who are unable to exercise choice.

The issue had been raised in a Commons debate by a Tory MP, David Faber, whose constituents include Cow and Gate Nutricia. The regulations on baby milk are to be finalised this month.—JOHN WARDEN, parliamentary correspondent, *BMJ*

Battles continue over baby milk

Australians investigate hepatitis C cases

Infection control procedures in Australia are under renewed scrutiny as health authorities investigate the possibility that patient to patient transfer of hepatitis C may occur. The New South Wales (NSW) health department fears that five patients contracted the disease after visiting a private hospital in Sydney on the same day in January last year. Federal health minister Carmen Lawrence has warned that the government could intervene to ensure that hospitals follow the strict guidelines laid down to avoid infection. A national review of the guidelines was recently carried out after reports late last year of the first recorded case of patient to patient transmission of HIV. Four women became infected after undergoing minor surgery at a doctor's rooms in Sydney on the same day. One patient has already died of an AIDS related illness.

In the hepatitis cases investigations are proceeding, but the health department has

found that there was no common use of equipment, such as scalpels. Dr George Rubin, the NSW health department's director of epidemiology, said that two patients developed acute hepatitis C last year, several months after having surgery at the Macarthur private hospital on the same day.

The hospital did not notify the health department but conducted its own investigations. "There was a strong belief that the two cases were a coincidence. There was not great urgency," said Dr Barry Catchlove, managing director of Health Care of Australia, which owns the hospital. Then tests identified three other patients with the disease among 49 people who had had surgery at the hospital on the same day, the day before, or the day after. The only common factor in all five cases was that the patients had received an anaesthetic.

The New South Wales opposition health spokesman, Dr Andrew Refshauge, said that cutbacks in state health budgets meant that hospitals were not employing the best infection control procedures.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

British government looks at effects of wealth on health

The British government is to examine the links between social inequalities and health as part of its continuing review of the *Health of the Nation* targets. This comes after more than a decade of official reluctance to discuss the issue.

A new interdepartmental working group will be chaired by Dr Jeremy Metters, deputy chief medical officer, who announced the formation of the new group at a conference on social inequalities and health organised by the BMA and the European Public Health Alliance. In a message welcoming the conference Mrs Virginia Bottomley said: "The reason for variations in health are likely to be the result of a complex interplay of biological, social, environmental, cultural, and behavioural factors. We need a better understanding of how these factors interrelate and at what points it is possible to undertake effective interventions."

The two day conference, attended by over 100 participants from 16 countries, came up with numerous suggestions for interventions. These included directly attacking the socioeconomic factors most closely associated with poor health—such as low income, unemployment, and low educational achievement—and actions aimed at factors that may mediate the effects of low income—such as poor housing and access to nutritious, affordable food.

The importance of national economic policies to health emerged as one of the key themes of the conference. Policies on taxation, employment, and social security benefits are all likely to affect people's socioeconomic circumstances. "Economic policy is therefore an important and legitimate part

Poor housing can contribute to poor health

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of public health," said Dr Mel Bartley of the University of London.

A much closer collaboration between public health activists and economists may be one of the conference's most important legacies. Evidence from the rapidly developing countries of south east Asia suggests that economic growth does not have to increase social inequality. "Integration of the public health view with that of economists is not possible," said Professor Johan Mackenbach of the Erasmus University in the Netherlands.

Professor Louise Gunning-Schepers of the Institute of Social Medicine, Amsterdam, said, in summing up the conference, that a common methodology to evaluate interventions for reducing inequality was urgently needed. She also repeated the hope that in future such conferences would include participants from socially disadvantaged groups.—TONY DELAMOTHE, *BMJ*

Report criticises French hospitals

The French system of public hospitals has been accused of being riddled with financial irregularities, poorly administered, and ill adapted to the health needs of the population. The attack comes in the annual report of the Inspectorate General of Social Affairs (IGSA), which claims that public hospitals tend to prolong admissions to get more money and that staff numbers are often increased beyond what is necessary.

The report also finds that hospital doctors, who are authorised to see a limited number of patients in public hospitals, sometimes take advantage of that privilege to the extent that the share between public and private activities "is more favourable to some doctors than it is to users." The IGSA also finds that the

hospital system is becoming more rigidly run by established doctors and professors who take on hospital appointments and do not carry their share of the workload.

The report abounds with examples. The public hospitals administration had estimated that the cost of paying staff during holidays in 1992 would amount to Fr379m (£48m); in fact it ran to Fr1.8bn (£230m). In one surgery department with three hospital doctors and one associate assistant, the assistant does 75% of the emergency duty at weekends and 35% on weekdays. Numbers of hospital staff increased by 34% between 1979 and 1990, while the number of admissions increased by only 14%.

The IGSA also deplores the decrease in the proportion of young doctors hired by hospitals and the increased use of foreign doctors and surgeons to carry out work that older physicians do not want to do. The same criticism was voiced by Professor Maurice Mercadier of the Academy of Medicine, who reported that recently only a third of hospital internships were awarded to French doctors while the others went to foreign doctors, who do not have the French medical diploma or an equivalent. French legislation does not allow such foreigners to have a private practice, but they can be recruited to work in the public sector. According to Professor Mercadier, 7900 doctors (nearly a quarter of the 33 000 hospital doctors in the country) are foreign doctors.

Hospital expenditure represents about 47% of health care costs in France, and the ministry of social affairs and health intends to reduce by 22 000 the number of hospital beds in the country. But the IGSA is sceptical, citing the example of one hospital where it took 67 meetings of staff, totalling 17 days, to eliminate nine hospital beds.

Hospital doctors are not happy about the situation either. Dr Francis Peigné, president of the union of hospital doctors, has complained of a "slow degradation of hospitals" and a "growing malaise" among

hospital staff. He said that the government does little more than patch things up, whereas a renegotiation of the conditions for hospital doctors is needed. "It's time for a pilot to be in the plane," he said, warning of possible social unrest in the sector.—ALEXANDER DOROZYNSKI, medical journalist, Paris

Paediatrician wins complaints case

A consultant paediatrician in Britain who had been suspended on full pay for nearly 12 years after a complaint about her behaviour with colleagues won her case last week. North Thames Regional Health Authority settled Bridget O'Connell's claim for an undisclosed sum and allowed her to take early retirement with the status of honorary consultant. Dr O'Connell, aged 59, has been pursuing legal proceedings for breach of contract since 1990.

North Thames, which includes the former North East Thames Regional Health Authority, told Dr O'Connell shortly after her suspension in 1982 that it would hold an inquiry which might lead to disciplinary action against her, but this never took place. The authority said that the case had been allowed to drift because guidelines on disciplining senior doctors were vague. New local procedures had been introduced, which the Department of Health has been urged to implement nationally.

Dr O'Connell was employed by North East Thames Authority in 1977. She worked mostly at King George Hospital, Ilford, where she soon began to criticise nursing standards in the paediatric ward and what she considered to be inadequate care of newborn infants. In November 1982 the regional medical officer asked her to go on special leave immediately. He later wrote explaining that he had received a complaint about her "ability to relate effectively with clinical colleagues." In another letter he said: "I'm afraid there is a strong feeling that it would be impossible for you to re-establish con-

structive personal relationships with your consultant and nursing colleagues after all you have said and done over the last four years."

Since then Dr O'Connell has remained suspended on full pay of about £50 000 a year. The Medical Defence Union started representing her in 1990.

In an agreed statement North Thames said that it would close its disciplinary case and withdraw all allegations against her. "The authority recognises, and greatly regrets, the distress which Dr O'Connell has felt as a result of being suspended and having these allegations hanging over her head. It also regrets the damage this may have done to her professional standing. The authority further recognises the sincerity of Dr O'Connell's concern to maintain the highest standards of patient care."

Dr O'Connell said: "Now that my case has been settled there should be an urgent review of procedures for ensuring professional freedom of speech, and of procedures for the suspension of consultants."—OWEN DYER, freelance journalist, London

Focus: Westminster

Workshop manual for the NHS

Next week British MPs on the health select committee will be in Oregon to see health rationing in action. The visit is in pursuit of their inquiry into priorities in the health service.

Last week the United States health secretary, Donna Shalala, was in Britain seeing how the NHS works, in her pursuit of American health care reform. They are, all of them, politicians in search of a grand design for universal health care. We shall see the results of their efforts in due course.

Meanwhile, the NHS is entering the fourth year of a grand design that has got beyond the prototype. The 1990 white paper *Working for Patients* was by way of being the showroom model. The subsequent NHS and Community Care Act 1990 to make the reforms work, was the owner's handbook. And there is also now a workshop manual, full of technical jargon, whose purpose is to translate health policy into action. It is called the NHS Executive business plan, and the 1994-5 edition has just appeared, containing 83 specific objectives. These imply some restyling of the 1990 model as well as modifications under the bonnet.

In contrast to the "steady state" approach of the early business plans, Alan Langlands, the new NHS chief executive, forecasts that the NHS faces "a period of considerable change over the next two years or so." For a

start, there is to be new primary legislation. A health services bill will convert the English regions, already reduced to eight, into regional offices of the NHS Executive. There are knock on effects, not least for medical schools. The new bill will also facilitate the merger of district and family health services authorities, making them more effective purchasers—intensifying competition in the internal market, in case anyone hoped that concept had lapsed. How much else is loaded on to the bill—such as amending the Medical Act 1983 to deal with incompetent doctors or enacting a new complaints procedure—is about to be thrashed out. The prospect of legislation will reopen the political debate about devolution and accountability, which is causing tension at many levels in the reformed NHS.

The business plan is dutifully tied to a number of the secretary of state's "priorities and key challenges" for improving the health of the nation. Inevitably, there are clinical priorities and key challenges. Objective 2, for example, is to agree with the medical royal colleges and deans that key *Health of the Nation* principles are inculcated "from entry to medical school to retirement"—in other words, health promotion for doctors. Objective 56 is even more intriguing. It envisages a comprehensive strategy for medical education, with a possible white paper by October 1995. Many would say not before time. Objective 69 aims to save money by eliminating clinical treatments that are ineffective. Good practice guidelines will be written into

purchasing contracts. But the promise is that it will be done in easy stages, and not by men in grey suits telling those in white coats what to do.

The coming year also holds change for general practice, with the extension of fundholding to all family doctors who want it. Objective 27 is to manage the continuous evolution of the general practice contract, including out of hours cover and the extension of audit. A continuing policy is to develop primary care systems that can call on more support from the hospital service. The changing configurations of health services in the big cities—London, Manchester, Newcastle, Bristol, and Birmingham—will also preoccupy the executive in the year ahead. There is also the imperative to improve community based services for mentally ill people, with the innovation of supervision orders.

Relentlessly, the business plan lists its objectives—an expansion of clinical audit, the reform of specialist medical training, abolition of central controls on medical staffing numbers, and the production of hospital league tables. The application of "skill mix" in hospitals will begin to erode professional boundaries, but those managing the NHS will have to obey a strict new corporate code. It all sounds heroic, except for a warning to stand by for mid-year revisions in October. Who knows, by then there could be a new secretary of state—and a different set of priorities and key challenges.—JOHN WARDEN