Pressure mounts over patients with hepatitis C

The British government is coming under pressure to compensate haemophilic patients and others who have contracted hepatitis C from contaminated blood or blood products after the revelation that 12 haemophilic patients have died of liver disease in the past year.

Some 2000 haemophilic patients are thought to be infected—most of the adult haemophilic patients who rely on regular treatment with blood clotting factors. All were infected before heat treatment of blood products began in 1985. A further 3000 patients without haemophilia who received blood transfusions before September 1991, when screening for hepatitis C virus began, are also thought to be infected, most of them without knowing. Victims of the latest tragedy seem set for a replay of the compensation battle waged in the 1980s over blood and blood products contaminated with HIV.

The Department of Health refused last week to extend the £42m settlement reached in 1991 to people infected with hepatitis C. "The government does not have a policy of no fault compensation," said a spokesperson. "Patients received the best medical treatment in the light of medical knowledge at the time." The Department of Health has always insisted that the settlement for those infected with HIV was a one off settlement. The settlement was extended in 1992 to include non-haemophilic people infected by blood transfusions and tissue transfer.

The Haemophilia Society is urging the government to give financial help to those who are most seriously affected and to the families of those who have died. Haemophilic patients have joined a group legal action against the government. But the legal claims could fall foul of a clause in the 1991 settlement whereby haemophilic patients agreed not to pursue claims for infection with hepatitis C virus before the settlement.

Graham Ross, one of the solicitors representing victims, said, "One argument is that the disclaimer should be of no effect because the knowledge that the plaintiffs and indeed their lawyers had of basic facts is now seen to be inadequate. At the time, HIV was seen as a short to medium term death knell, and by comparison hepatitis seemed a fairly minor infection. But the majority of haemophiliacs with HIV are still asymptomatic 10-12 years after infection."—CLARE DYER, legal correspondent, *BMJ*

Battles continue over blood

German parliament investigates HIV infections

One of the first challenges facing the newly elected members of the lower house of the German parliament, the Bundestag, is the issue of HIV infection transmitted by blood and blood products. A report on this subject just published by a parliamentary investigating committee concludes that about 60% of the cases of HIV infection in haemophilic patients caused by blood products in the early 1980s could have been avoided if protective measures had been taken early enough.

The chairman of the investigating committee, Gerhard Scheu, said that as about 1400 of more than 2000 HIV infected haemophilic patients in Germany had received contaminated preparations of factor VIII at a time when the viral nature of the AIDS pathogen was already known, these patients had carried an unnecessary risk.

Methods to eliminate living pathogens such as hepatitis viruses from donor blood and blood preparations had already been developed in the '70s. Nevertheless, the health ministry in Bonn and the federal health office in Berlin, for whatever reasons, neglected early warnings from scientists and hesitated to remove suspicious blood products from the market immediately. Such products were not removed until 1985.

This new parliamentary report clearly

Headlines

Catholic bishops forbid euthanasia:

Catholic bishops in the US say that euthanasia and assisted suicide must never be allowed at the 1200 Catholic hospitals in the US, which form the largest health care system. They say that doctors may give drugs to control pain to people who are terminally ill and that patients have the right to forgo extraordinary means of extending life.

Swedish step up care for elderly people:

Social services departments in Sweden now provide home help to three times as many disabled and elderly people as in the mid-1960s. More than a third of those aged 80 or more received some form of home help last year, as did 14% of those aged over 64.

Managers receive high rewards:

A survey by Health Database shows that 45 directors and other managers of NHS trusts earn between £90 000 and £100 000; six are paid over £100 000.

NHS earns £170m from private beds:

The NHS raised £170m from pay beds in NHS hospitals, according to the *Fitzhugh Directory of Independent Healthcare*. The NHS's share of the private short stay market has grown to 14.7% from 10.9% in 1990.

Portugal tops salmonellosis list:

In a test of 1700 samples of chicken from the European Union, Norway, Sweden, and Slovenia, Portugal had the worst record: 48% of the samples contained salmonella and 60% campylobacter. There was no salmonella in Norwegian and Swedish chickens.

NHS will not withdraw from continuing care:

The NHS's chief executive, Mr Alan Langlands, has said that some health authorities will have to reinvest in health care for chronically ill, old, and disabled people because they have reduced services too far. Leeds Health Authority was castigated by the NHS ombudsman for failing to provide care for a paralysed patient with stroke.

Police investigate claims of sabotage in British hospitals:

Police investigating two deaths at an intensive care unit in Nottinghamshire in Britain are considering a link with similar incidents in which equipment was allegedly sabotaged. Officers have been tracing the career of a nurse who also worked in eight other hospitals.

states that there was a political responsibility in the case, but it does not mention the names of Rita Sussmuth and Heiner Geissler, who were ministers for health at that time. However, it was Rita Sussmuth, now president of the lower house of parliament, to whom the report was solemnly handed in front of television cameras.

The authors of the report want the federal government, the German states, the pharmaceutical industry, and hospitals and doctors involved to establish a fund of DM400m-700m (£164m-287m) to compensate the survivors who became infected through contaminated blood products and their relatives. The investigators say that compensation payments of up to DM500 000 (then about £170 000) per patient, which were paid by the pharmaceutical industry after an extrajudicial settlement in 1987, were insufficient because they did not imply guilt on the part of the government. The committee has also recommended that the German government should follow the example of France and apologise publicly for the affair.—HELMUT KARCHER, medical writer, Munich

Queen's speech heralds health bills in Britain

New powers for the General Medical Council to discipline doctors whose performance is seriously deficient are included in the legislative programme of the British parliament for the 1994-5 session, which opened last week (see also Focus on p1394). A bill extending the Medical Act was one of three health measures in the Queen's speech. Of the others, one will streamline the administration of the NHS in England and a second will introduce supervised discharge for mentally ill patients. Though it is the heaviest agenda of health legislation for some years, all the bills seek to amend existing provisions rather than to innovate.

The bill to enable the General Medical Council to deal with doctors whose professional performance is found to be seriously deficient will set up two statutory committees to investigate complaints and, when necessary, arrange remedial training. The committees will be known as the assessment referral panel and the professional performance committee and will deal mainly with doctors who refuse to submit to local screening and assessment. The new procedures, which could lead to a doctor's registration being suspended, will meet long-standing concern that the disciplinary remit of the council covers only serious professional misconduct and that the council has no jurisdiction where it is evident that a doctor's performance is consistently poor. An estimated 150 cases a year could be referred to a performance screener, who would decide whether to investigate further.

The main item of legislation, the Health Authorities Bill, will underpin the devolved NHS management structure for England. The

bill will abolish all regional, district, and family health services authorities from April 1996. The eight existing regional health authorities will become regional offices of the NHS Executive to monitor the performance of NHS trusts.

At local level about 100 all purpose authorities will replace the present 111 district and 92 family health services authorities. The new authorities will purchase health services to meet local needs and ensure the provision of primary care. The bill is expected to produce substantial management savings in addition to economies worth £30m so far. The eight regional offices will employ a maximum of 1110 staff, compared with 3900 working for the regions two years ago.

A mental health bill will strengthen the powers to supervise patients with a serious mental disorder who need special support after discharge from hospital. A new power of supervised discharge will require a patient to comply with a care plan under a named key worker. Failure to cooperate would lead to an immediate review of the case, with the possibility of recall to hospital under the existing provisions of the 1983 Mental Health Act. The bill will extend from six months to one year the "long leash" of extended leave, during which patients can be recalled to hospital. It will also correct the anomaly whereby a detained patient who absconds for 28 days cannot be returned to hospital.

It is estimated that up to 3000 patients may be subject to supervised discharge in the community. They are mainly schizophrenic patients who relapse after failing to continue their treatment and may become a danger to themselves and others. Public concern was heightened by the killing of Jonathan Zito at a London underground station by Christopher Clunis, a newly discharged patient. In another incident a man climbed into the lions' den at London Zoo.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Queen on her way to the House of Lords

MICHAEL POWELL/THE TIMES

Stress case paves way for damages claims

Employers are bracing themselves for a rash of claims for damages for injuries related to stress following last week's historic victory by a social worker who claimed that his workload had caused a mental breakdown that ended his career. Among the likely claimants are hospital doctors, a handful of whom have already consulted the BMA's legal department. Three cases have come in within the past month, according to the department's head, Chris Hughes.

John Walker, who was retired from his job as a social services area manager on medical grounds after suffering two breakdowns, is the first employee in Britain to sue an employer successfully for stress from overwork. Lawyers said that the case would open the floodgates for workers subjected to excessive workloads to launch claims for damages.

Mr Justice Colman ruled that Northumberland County Council was liable to pay Mr Walker damages because of its unreasonable failure to provide a safe system of work; this ruling puts stress on the same footing as accidents at work or industrial diseases. Damages have still to be assessed, but Mr Walker's union, Unison, which backed his case, said that it was seeking a £200 000 payment. The union warned other employers that bosses who unfairly overworked their employees could face court action. The council is to appeal.

Mr Walker, a father of four from Whitley Bay, Tyne and Wear, who joined the authority in 1965, accused his bosses of having subjected him to "an impossible workload" as area manager for social services in the Blyth Valley area. In 1986 he suffered a breakdown, but when he returned to work the next year no steps were taken to ease his workload. He had a second breakdown and retired on medical grounds in 1988.

The judge said that the council "chose to continue to employ him but provided no effective help. In so doing it was in my judgment acting unreasonably and therefore in breach of its duty of care." He was satisfied on the evidence that, had the further assistance been provided to Mr Walker, his second breakdown would probably not have occurred.

Unison's general secretary, Alan Jinkinson, said: "This ruling is a warning to employers that they can no longer expect their staff to pay with their health while struggling to provide underfunded, under-resourced services."

The population of Blyth Valley increased from 65 000 to 80 000 during Mr Walker's 13 years as area manager. He repeatedly sought extra staff and administrative back up, but his requests were refused. Mr Walker, now working as a self employed decorator, said outside court: "More and more was being squeezed out of the same pint pot. Obviously I tried my best. I was told to get on with it."

Victory for Mr Walker

JOHN VOOS/THE INDEPENDENT

The High Court is expected to deliver judgment before Christmas in another case of stress, brought by Ray Petch, a senior civil servant who retired early after a breakdown, against the Department of Health and Social Security. He has lost a similar case against Customs and Excise, where he also held a senior post.

A five year battle over junior doctors' hours is due to reach the High Court next May. Chris Johnstone, then a senior house officer at University College Hospital, London, sought a declaration that Bloomsbury Health Authority could not lawfully require him to work up to 100 hours a week. The authority tried to have the action struck out, but the Appeal Court ruled that an employer could be acting unlawfully by requiring an employee to work hours that could damage his or her health.—CLARE DYER, legal correspondent, *BMJ*

Oregon's voters approve assisted suicide measure

Voters in Oregon have approved a measure giving doctors the right to prescribe a lethal dose of a drug to terminally ill patients. Measure 16 was approved in this month's mid-term elections in the US by 53% to 47%, in contrast to similar measures in Washington state in 1991 and California in 1992, which were defeated (*BMJ* 1991; 303: 431).

Measure 16 says that a qualifying patient (a capable adult and resident of Oregon) with six months or less to live can ask the attending doctor for drugs to end his or her life with dignity. At least two doctors must first agree that the patient's condition is terminal. The patient must make the request at least three times, and the third request must be in writing. The patient can rescind the request for the drugs at any time, and there is provision for counselling if either the

attending or the consulting doctor believes that the patient is suffering from a psychiatric disorder such as depression.

Dr Peter Goodwin, chair of the Oregon Right-to-Die Committee and an associate professor in family medicine at Oregon Health Sciences University in Portland, said: "Measure 16 differs significantly from the past initiatives from Washington and California. We excluded active voluntary euthanasia by the doctor. The initiative and responsibility start with the patient." He said that the Oregon Medical Association did not directly oppose Measure 16 at its annual meeting but instead appointed a task force on issues for dying patients. Measure 16 becomes law on 8 December. Dr Goodwin thought it unlikely that the Oregon legislature would try to modify it, given the strength of antigovernment feeling among the electorate.

The 40 000 member Hemlock Society USA, which has led the fight for death assisted by a doctor since 1980, said, "The passage of Measure 16 is a ground breaking victory for the people of Oregon."

The American Medical Association issued a statement saying: "We are disappointed in the outcome of Measure 16 in Oregon. The AMA's Council on Ethical and Judicial Affairs' opinion is that physician-assisted suicide, even under the limited scope of the Oregon measure, is unethical and goes against the unalterable role of physicians as healers."

Dr Arthur Caplan, director of the Center for Bioethics, University of Pennsylvania School of Medicine, in Philadelphia, said that the federal government might bring suit on the grounds of unlawful interstate commerce if terminally ill patients travelled to Oregon—the so called "fly and die" option. Insurance companies might go to court to avoid paying death benefits in cases of assisted suicide. Dr Caplan said that Measure 16 was likely to lead to pressure on sick old people to end their lives. For that reason he would not have voted for it. —FRED B CHARATAN, freelance journalist, Florida

Out of hours deal rejected by general practitioners

British family doctors have overwhelmingly rejected a package on out of hours cover because of what they see as derisory pricing. The package, which has been put together after many difficult negotiating meetings with the Department of Health, would offer general practitioners an average of £2000 a year plus £9 for each consultation between 10 pm and 8 am.

There was anger and dismay at last week's meeting of the General Medical Services Committee when members realised that the government had priced their services at 2.8p per patient per week while at the same time acknowledging "the particular stresses faced by many doctors when offering services to their patients in the evenings, nights, and weekends."

The GMSC rejected the package by 53 votes to eight. Proposals to ballot the profession and consult local medical committees were defeated: speakers said that it was for the GMSC to make the decision. Dr Eric Rose, secretary of Buckinghamshire Local Medical Committee, said, "We are going back to the pre-1990 situation with the basic practice allowance and a night visit fee." Dr David Pickersgill, a general practitioner in north Norfolk, was concerned that a £9 fee for a night visit might deter some doctors from visiting and that this could lead to an increase in complaints by patients.

The chairman, Dr Ian Bogle, told the committee that the deal did not have the commendation of the negotiators, and he warned that the document could jeopardise out of hours care. The committee was in a

difficult position, he said, because there were potential gainers as well as losers from the proposals. Dr Bogle intends to seek an urgent meeting with the health secretary.

The pay package is the latest in a series of steps taken to ease the problems of out of hours cover; night visits have increased fivefold in the past 25 years, and doctors have complained that many of the calls are not for genuine emergencies. The government has already amended legislation so that deputising doctors, rather than the patients' own general practitioners, are responsible for their actions; it has instructed family health services authorities to be flexible in allowing doctors to take time off after heavy on call duties; it has started a "help us to help you" campaign to help doctors educate their patients about the appropriate use of services; and it has agreed to amend legislation to clarify doctors' obligations with respect to patients who are seen by doctors in primary care centres outside surgery hours.

Despite calls in the past three years for the GMSC to negotiate alternative arrangements, this year's annual conference of representatives of local medical committees voted to retain 24 hour responsibility for their patients. One of the deputy chairmen, Dr John Chisholm, said that the Department of Health's latest move was "a destructive way to turn the clock back." The question of 24 hour responsibility was now back on the agenda.

The committee accepted some of the principles in the new package. Firstly, the abolition of the existing higher and lower night visit fees is conference policy. At present general practitioners receive £47.85 if they do a night visit and £15.95 if they use a deputising service. The GMSC acknowledges that for some doctors this has been a perverse incentive to do more visits. The committee also sees merit in a fixed payment

supported by a smaller item of service fee for night visits; the item of service element would be paid to principals, trainees, assistants, or associates wherever the consultation took place.

The government has always insisted that any new arrangements must be at nil cost, and the GMSC's anger has been compounded by the statement that "an extra £6m" will be put into cash limited general medical services to support general practice cooperatives. The £6m in fact comes from money released because of the discounts that dispensing doctors obtain on the drugs and appliances they buy. "It is outrageous to say that it is new money," one of the GMSC's negotiators, Dr Brian Goss, said. The money released, he said, should be available to all doctors and not just to those who are able to use cooperatives.—LINDA BEECHAM, *BMJ*

Debate over US Gulf war syndrome continues

Evidence is accumulating that the so called Gulf war syndrome has affected not only soldiers who served in the war in 1991 but also their partners and perhaps their children. About 20000 of the 700000 American troops who served in the Gulf war have signed a register of potential sufferers of the syndrome, which has been said to cause fatigue, myalgias, and other vague symptoms.

Late last month 400 preliminary responses in a survey of 1000 of those on the register showed that 78% of their spouses and 65% of their children born since the war had suffered some sort of unusual symptoms, according to a spokesperson for Senator Donald Riegle, who has led congressional investigations into the reports.

The Pentagon has refused to recognise the symptoms as a disease, although it also says that it cannot be sure that it is not a disease. Among the symptoms attributed to the syndrome are severe fatigue, rashes, headaches, myalgias, arthralgias, chest pain, dyspnoea, memory loss, sleep changes, and diarrhoea.

Various investigators have hypothesised about possible sources, including infectious agents and toxic chemicals. Soldiers in the Gulf were exposed to fumes and smoke from oil well fires, paints, pesticides, and uranium. Many also received pyridostigmine bromide, an anti-myasthenia drug used to protect against chemical weapons; an unlicensed vaccine against botulism; and a licensed vaccine against anthrax.

Last week the *Los Angeles Times* reported anecdotal evidence of a greater than expected number of birth defects among children born to families living at Fort Bragg, home of the army's 82nd Airborne Division, an elite group that served in the Gulf. The newspaper also reported that local infant mortality had risen near military

Making a home visit—the government is accused of trying to pay general practitioners as little as possible

installations in Mississippi, Kentucky, Tennessee, Georgia, and Texas.

In Mississippi the newspaper report, said 13 of 15 children born to veterans of the Gulf war suffered serious birth defects. Mississippi's department of health investigated the local reports and determined that the rate of birth defects was normal in the area.

The Pentagon has denied that any evidence exists that ill effects have been transmitted to spouses and children. But at least two experts have told Congress that evidence exists that sperm can be environmentally damaged in such a way that they can implant mutated genes into human eggs, although the effects of such transfer have not been shown. In a separate investigation the US General Accounting Office reported that pesticides, oil fires, and efforts at decontamination could cause "reproductive dysfunction" in soldiers, though it added that such findings could not be extrapolated to families.

Last year Congress passed a bill that, while failing to legitimise the Gulf war syndrome, set up a fund to pay those veterans who suffered from the symptoms ascribed to the syndrome. But the bill did not provide payments or other support to families.

So far no scientific panel has validated claims attributed to the Gulf war syndrome. But the Institute of Medicine has assembled a panel of 10 experts to determine whether epidemiological evidence is sufficient to support claims and to make recommendations for the government to deal with the issue. A spokeswoman for the institute said that the report should reach Congress soon after it begins its 1995 session in January. —JOHN ROBERTS, North American editor, *BMJ*

Satisfied customers grow for NHS

Public dissatisfaction with the health service is falling steadily, according to the annual British survey of social attitudes. The number of people who believe that health should be the first priority for extra government spending has also fallen.

The survey shows that the proportion of people who were dissatisfied with the NHS fell to 38% in 1993, compared with 47% in 1990, when the health service market was poised to begin. The proportion of people expressing satisfaction with the NHS rose to 44% in 1993, compared with 37% in 1990.

These figures nevertheless show that more than one in three people remain dissatisfied with the health service, and the survey attempted to establish their main areas of concern.

Nick Bosanquet, professor of health policy at London University and author of the health section of the report on the survey, said: "Whereas the quality of the medical care provided by NHS hospitals largely receives a seal of approval, the time it takes to gain access to that treatment does come in for criticism." Thus, under one in three

Satisfied customers?

people say that the quality of medical care needs improvement and under one in four criticise the quality of nursing care. But in contrast, said Nick Bosanquet, "as many as eight in 10 believe that waiting lists are too long and around three in four feel they would have to wait too long to be seen in outpatient or accident and emergency departments."

The survey, carried out by the independent research institute Social and Community Planning Research, was based on interviews with 3000 people. Topics discussed included not just health but also education, spending and tax, welfare services, transport, and the environment.

When it comes to funding, the proportion of people who named health as the first priority for government spending fell sharply to 45% in 1993, compared with 61% in 1989 and 56% in 1990.

As far as personal spending on health is concerned, the survey shows that "not only has the demand for private health insurance fallen off, but so has the support for the principle of the better off purchasing better health care."

The survey also notes that those with the highest incomes are just as opposed to allowing people to pay for better health care as those with the lowest incomes.

Nick Bosanquet said: "There is no evidence that the reforms have undermined support for the principle of a universal health service. Rather, in so far as the reforms have in practice made the public more influential in how the service is run, they have broadened the base of support for that principle."

—CLUDIA COURT, *BMJ*

British Social Attitudes: the Eleventh Report is available from Social and Community Planning Research, 35 Northampton Square, London EC1V 0AX, price £16.50.

Locum doctors protest at strike breaking

Doctors have been flown from Australia to fill the places of striking junior doctors at Whakatane Hospital in New Zealand's North Island. Ten of the hospital's junior doctors are on a three and a half week strike. They want a return to hourly rates of pay and claim that they were being called back after a full day's work to perform duties normally done by other staff.

Eastbay Health Crown Health Enterprise hired the locum doctors after placing advertisements in Australian newspapers offering "an attractive salary package" with return air fares, accommodation, meals, a motor vehicle, and sightseeing tours. The advertisements did not mention any industrial action at Whakatane Hospital, but the dates of the locum appointments coincided exactly with those of the strike.

Dr Dennis Pezaro, chairman of the medical association, has criticised the overseas recruitment. "The needs of the people of Whakatane are best served by employing New Zealand junior doctors committed to care for people in our country," he said.

The Australians hired to fill the posts have complained that they were not warned of industrial trouble before they arrived in New Zealand.

The Public Services Association, which represents some of the Australian doctors, said that it was seeking legal advice about whether they were obliged to complete their contracts. The Australian union's assistant general secretary, Dr Brian Jardine, said that a representative of the doctors had contacted the union to complain about their

predicament. He said that one of the doctors was a branch president of the union and that they would not have travelled to New Zealand if they had known that they were to be used as strike breakers. One doctor has already returned to Australia before the end of his contract.

Dr Pezaro said that the crown health enterprise should be negotiating with the resident doctors rather than offering lucrative contracts to Australians.

Eastbay Health's human resources manager, Mr Stan Austin, said that it was the New Zealand doctors' union that was refusing to sit down at the negotiating table. In view of the refusal by the union to provide emergency cover during the strike, he said, the crown health enterprise had had no alternative but to bring in extra staff.

However, Mr Ross Henderson, union advocate for the striking New Zealand doctors, said that the hospital's revised offer was unacceptable as it proposed that an extra house surgeon should be hired out of the salaries of those already on the payroll. —CHARLES ESSEX, community paediatrician, Auckland

Victims of violence flood Rio's hospitals

A 13 year old schoolgirl has become the 40th child with bullet wounds to be treated at Rio de Janeiro's Souza Aguiar hospital since September, and the fourth to die. The girl had been hit in the head by a stray bullet during a police chase of a stolen car. Doctors in Rio say that they are now treating so many victims of gunshot wounds it is as if there were an undeclared civil war.

A total of 1500 people were treated for bullet wounds in the first six months of this year at Rio de Janeiro's three municipal hospitals, Souza Aguiar, Salgao Filho, and Miguel Couto. Doctors say that this is a huge increase on previous years. Speaking at a recent congress on hospital emergency services in Rio, police doctor Abouch Krimchantowski said that this was comparable to figures for the Bosnian war. "The difference is that there is no civil war in Brazil."

The violence is put down to the growing activities of drug gangs, who have taken

control of many of Rio's 670 shanty towns, and to the frequent shootouts between gangs and the police.

According to data from the Rio mortuary, 20 people die every day in the city as a result of armed robberies, shootouts, and gang violence.

Dr Krimchantowski said that doctors in public hospitals needed to be taught the difference between wounds caused by different weapons. Rio criminals are now using more sophisticated weapons, like the American AR-15 rifle and hand grenades. Wounds from the new high velocity weapons are much more severe than those caused by the .38 revolvers still used by the police. Staff at Rio's public hospitals also say that they are having to work in overcrowded, understaffed casualty departments.

In 1989 the Salgado Filho hospital treated 72 600 patients in casualty; in the first nine months of this year it treated 132 500. Souza Aguiar treats between 900 and 1200 a day in its emergency wards, and sometimes the corridors are so crowded with stretchers it is difficult to move around. —JAN ROCHA, Brazil correspondent, *Guardian*

Focus: Westminster

Parliament prepares for a health audit

For an administration that shies away from health legislation the British government is in the unlikely position of having to pilot three separate health bills through the new

session of parliament (p 1389). Having previously thought themselves overexposed with one bill, ministers will now have to put their heads above the parapet three times: on health service restructuring, the performance of doctors, and supervision of mentally ill people in the community.

This all comes about because at a late stage the cabinet got cold feet about privatising the Royal Mail. The consequent gap in the Queen's speech prompted opposition assertions that after 15 years of office the Conservatives had finally run out of steam. That hit a sensitive nerve in Downing Street and the call went out for departments to come up with more legislation.

Until that point the Department of Health had been limited to a single bill to abolish the NHS's regional tier. The other bills had been sidelined. None of these bills is particularly momentous or contentious; indeed, the medical profession will be delighted that time has been found to give the General Medical Council powers over doctors' performance. Nevertheless, together the three bills will ensure several months

of high profile medicopolitics.

This applies particularly to the Health Authorities Bill, which ties up the loose ends of the 1991 reforms. Its purpose is to create the eight regional offices of the NHS Executive and about 100 all purpose health authorities covering primary as well as hospital care.

This pattern is already taking shape as district health authorities and family health services authorities join together, and the new bill does no more than legitimise it. Pivotal to the new structure are the non-executive directors of the eight regions, who will be the Secretary of State's troubleshooters when anything goes wrong among the 419 self governing trusts.

The opposition will question whether the bill addresses the real problems of the health services or whether it simply replaces local administrators with civil servants. Labour supports a more integrated structure, but it is still contemplating its own alternative to the internal market. A policy forum in Cardiff last week began adding detail to Labour's earlier discussion document, *Health 2000*, for completion by autumn 1995.

There are signs that under Margaret Beckett Labour's health policy will be less confrontational than before. For instance, she will not oppose the bill to give the General Medical Council jurisdiction over doctors' performance. Her predecessor, David Blunkett, had wanted to open up the whole issue of professional self regulation.

Mrs Beckett thinks that the new powers are needed to fill a gap and do not impinge on a wider regulatory review.

Nor does Labour intend making a party political issue of the third bill—to introduce supervised discharge of mentally ill people from hospital. The measure raises ethical problems about compulsion, though public attention is focused on a succession of killings by schizophrenic patients who relapsed after being discharged back into the community. Supervised discharge under an agreed care plan is only part of the answer, though Labour suspects it is also a device by ministers looking for someone else to blame when things go wrong.

Taken together the three bills afford parliament a timely opportunity to take stock of the 1992 reforms. Outwardly, the government remains well pleased and can quote last week's British Social Attitudes Survey in support. This showed that the trend of rising disillusion with the NHS has been reversed and that more people are now satisfied than dissatisfied. According to the survey, the reforms are beginning to reduce the level of political conflict surrounding the NHS.

At the same time a leaked Conservative party memorandum tells the prime minister that the reforms could be an election loser. Parliament's audit also takes place against a background of pressure on the health budget, putting new strains on community care and producing possible tension over NHS pay. —JOHN WARDEN