New infection controls worry doctors in Australia

Australia's football players and health professionals are caught up in controversial new guidelines concerning the control of HIV infection, which they claim are akin to compulsory testing. The Australian Football League now has the power to demand that any players suspected of being infected with HIV or hepatitis B virus should have a blood test or face a £1000 fine. And in New South Wales the health department plans to make doctors, nurses, and dentists sign affidavits guaranteeing that they agree to be tested for HIV as regularly as every six months.

The Australian Football League has been attacked by the Australian Medical Association (AMA) and civil libertarians. Both groups claim that the rules are illegal and an invasion of privacy. The rules also require umpires to send off any bloodied player until the bleeding has stopped, the blood has been cleaned up, and the player's clothing has been changed. Earlier this month the first footballer was sent off under this rule during a match in Melbourne, once for having a gashed nose and later for having blood on his shorts.

Meanwhile health professionals across the state border reacted angrily to the New South Wales government's plans to insist on regular tests and disciplinary action, including deregistration, for those who break the agreement. The state's chief medical officer, Dr George Rubin, said that the infection control policy was to be approved as soon as next month. He said that it would change testing from a "professional" to a "legal" expectation.

The affidavit commits those who sign it to withdraw from invasive surgical procedures if a test for HIV or hepatitis B or C virus yields a positive result. It also means that those who indulge in high risk activities, such as unsafe homosexual sex and injecting drug use, have to remain free of infection even if they are not involved in invasive procedures. Dr Rubin said: "I think we are substantially upping the ante in infection control and trying to make the circumstances as tight as possible for health workers to follow without making testing compulsory. What we are saying is that you have a professional responsibility to your patient and yourself, and only you know if you are exposed. And if you are exposed, get tested."

The details came just one day after the department issued an alert asking more than 140 mothers who had given birth at a Sydney hospital to have tests after their doctor was found to be HIV positive. Surgeons have

Australian footballers oppose "compulsory" blood tests

COLORSPORT

branded the department's plans as tantamount to compulsory testing and say that if the scheme is to go ahead it should be matched by the compulsory testing of patients.

The vice president of the AMA, Dr David Weedon, said that he had never heard anything as ridiculous as the plans. "I am lost for words," he said. "New South Wales will be the only place to my knowledge in the whole world that has embarked on this knee jerk reaction." The AMA opposes compulsory testing but encourages those who perform invasive procedures to be tested every six months.—CHRISTOPHER ZINN, Australian correspondent, *Guardian*

More patients wait but for shorter time

The number of patients who have been waiting more than a year for treatment in England has gone up slightly since March but is down compared with this time last year, according to government figures published last week. Provisional figures on waiting times show that 0.1% more patients had been waiting for treatment for between one and two years at the end of June than at the end of March. The total number of patients waiting for treatment at the end of the second quarter of this year was 1 070 887. This figure is up by 0.5% on the first quarter, compared with a 2.3% rise last year.

Announcing the figures, Tom Sackville, parliamentary secretary for health, said that the number of patients who had been waiting over one year for treatment had dropped by more than 1000 to 64 625 compared with the figure for the same time last year. He claimed that the figures represented the best first quarter performance of the NHS for four years.

The minister pointed out that the number of people who had been waiting more than one year had been slashed from 170 000 since the NHS reforms were introduced. "Half of all admissions into hospital are immediate," he said. "Of those admitted from waiting lists, half are admitted within five weeks, nearly 75% within three months, and 98% within one year. What matters to patients is not how many people are on the waiting list but 'How long do I have to wait?'" He reported that since 1988 the average waiting time for patients had fallen from over nine months to less than five.

The figures showed that only 447 patients had been waiting for treatment for two years or longer by the end of June. Of these, 444 were waiting for in vitro fertilisation at Hammersmith Hospital.

The minister announced that two new targets would be introduced into the patient's charter from next April. These would require all patients needing heart bypass surgery and some associated procedures to be treated within 12 months and all patients to be given an outpatient appointment within a specified time.

But Labour's health spokesman, David Blunkett, said that the figures showed the

Headlines

US tobacco companies face trial:

Lawyers acting for Burl Butler, a non-smoking barber from Mississippi who died of lung cancer in May, want a state judge to rule that United States tobacco companies should hand over internal records about research into the addictiveness of nicotine and dangers of secondhand smoke. The companies cannot claim, as they have with smokers, that Butler knew the risks from smoking.

More patients with HIV contract tuberculosis:

The number of people in Asia who develop tuberculosis because they are infected with HIV and the tuberculosis bacillus is expected to multiply nearly sevenfold before 2000, according to the World Health Organisation. Between 52% and 70% of people with AIDS in Thailand, India, and Nepal have developed tuberculosis.

Increase in meningococcal infections:

The Public Health Laboratory Service has reported that the incidence of meningococcal disease rose in Britain late in 1993, apparently affected by the influenza epidemic. The number of statutory notifications reported to the Office of Population Censuses and Surveys was higher than the number of laboratory diagnosed cases.

Contract signed for North Herts pathology service:

The North Herts NHS Trust has reached agreement with Unilabs/JS Pathology to provide a comprehensive pathology service at the Lister Hospital from 1 December. The five consultant pathologists will continue to be employed by the trust; 60 other staff will transfer to the company on their current terms and conditions of service.

Department of Health's soaring publicity budget:

The Department of Health's advertising and publicity budget has increased from £4.5m in 1985-6 to a projected budget of £25.3m this year. The department has one of the largest press departments, and recent campaigns include £150 000 spent on leaflets answering questions about London's health service, £640 000 on warning of the dangers of diseases abroad, and £1.3m on the organ donor campaign.

total failure of the government's changes in the NHS: "Waiting lists have risen dramatically again, to another all time record total of 1.07 million, as over 5000 more people join the official queues." If those waiting for a first consultant appointment were included, he said, the true waiting list was 2.3 million.

Dr Sandy Macara, chairman of the British Medical Association's council, said that he was pleased that the secretary of state, Virginia Bottomley, had taken on board the association's suggestion that care must be related to clinical need. "The association has always said that it is not so important how many people are on the waiting list but how long they have been waiting and how that relates to the care they actually need." The reforms must be judged on these criteria, he said. "These figures do not show one way or another whether the reforms have been a success."—SHARON KINGMAN, freelance journalist, London

Government clarifies long term NHS care

Criticism that the NHS is neglecting the long term health care of elderly people has prompted the Department of Health to clarify its responsibilities. As a result, health authorities are being told to reassess their provision for long term health care. But the Labour opposition and voluntary organisations say that many ambiguities remain.

Draft guidance issued for consultation by the NHS Executive requires health authorities to make "appropriate provision" and to draw up local criteria for eligibility. Some authorities now purchase no long term health care for elderly people. The guidance also insists that patients are entitled to a clear decision on whether they are eligible for continuing care in the NHS, which is free—

although the stated expectation is that the "significant majority" of people who require care in a nursing home will have their needs met through community care by social services, which is means tested.

In a statement accompanying the guidance junior health minister John Bowis said: "There is much misinformation on this subject. Elderly people are being led to believe, wrongly, that the NHS has suddenly lost responsibility for their health care."

The NHS Executive expects all health authorities to show that agreed policies and criteria for eligibility for continuing care in the NHS are reflected in their contracting intentions for 1995-6. The NHS's responsibilities for long term care are listed as including acute medical care, rehabilitation, general medical services, community health services, and continuing care in an NHS hospital or independent nursing home.

If a consultant or general practitioner decides that a patient no longer requires short term treatment but is likely to need intensive long term support, including care in a nursing home or residential home, the patient should be eligible for a multidisciplinary assessment of needs. Patients and their families should be fully informed about the local options for long term care.

One of the main impetuses behind the new guidance was criticism by the NHS ombudsman, William Reid, of Leeds Health Authority for discharging a 55 year old man severely incapacitated by a stroke to a nursing home for which his family had to pay. He was reinstated to NHS care.

The NHS Executive says that it is essential that local authorities, health authorities, and general practice fundholders work collaboratively over the provision of long term health care and social care. Comments are invited by 14 October.—JOHN WARDEN, parliamentary correspondent, *BMJ*

NHS Responsibilities for Meeting Longterm Health Care Needs is available free from the Community Care Unit, NHS Executive 3N21, Quarry House, Leeds LS2 7UE.

The NHS retains responsibility for elderly people's health care

CAROLINE PENN/IMPACT

New code will cover confidentiality in the NHS

Patient confidentiality in the NHS is to be covered by a new code of conduct—the first of its kind—drawn up by the Department of Health. A draft was issued last week for consultation, just one week after a rival version—seeking statutory status—was produced by an interprofessional group which included doctors (6 August, p 360). The government has decided on legal advice that confidentiality is adequately protected by the common law and that non-statutory guidance is sufficient. The BMA and other professional organisations insist that the current law is inadequate and that legislation is needed to protect patients.

The department's guidance is based on the principle that information about the health and welfare of a patient is confidential and should be disclosed only to those who need to have it in order to provide, plan, and manage care and treatment. Everyone working in the NHS is stated to be under a legal duty to safeguard confidentiality.

Information may be disclosed within the NHS on the basis of the patient's implied consent, but disclosures must be on a strict "need to know" basis. The minimum necessary information should be disclosed, and it should be anonymised when the recipient does not need to know the patient's identity. Care should be taken that confidentiality is not accidentally breached by, for example, conversations being overheard, files left unattended, or careless computer security. Unauthorised disclosure could lead to disciplinary action.

Patients implicitly authorise their records to be used for wider health purposes, including clinical audit and research, as well as administrative functions such as the planning and payment of services. The duty of confidence is not absolute and may be overridden by court orders, statutory notification procedures, or the public interest (for example, reporting of adverse drug reactions). Those who work in the NHS are warned to be on their guard against people who seek personal information by deception, such as by posing as a doctor or relative.

Junior health minister Tom Sackville said: "This is the first time that we have offered comprehensive guidance on the subject of confidentiality. Much of it is common sense, and it will not contain any surprises for those who handle confidential information about patients." A BMA spokesperson said: "We are looking at this very carefully and we will be responding to the Department of Health, but it certainly doesn't appear to go as far as we would wish in terms of legislation." Comments are invited by 9 December.—

JOHN WARDEN, parliamentary correspondent, *BMJ*

Confidentiality, Use and Disclosure of Personal Health Information is available free from the Department of Health, Health Care (Administration) Division 4D, Wellington House, 135-155 Waterloo Road, London SE1 8UG.

All NHS workers have legal duty to safeguard confidentiality

PETE ARKELL/IMPACT

Danish government orders closure of transplant centre

The Danish health ministry has ordered the closure of one of the country's two liver transplant centres. The decision follows a lengthy wrangle about whether the Aarhus unit, where the mortality is twice as high as the European average, should have been created in the first place.

The unit, based in Denmark's second largest hospital, has been the subject of a highly critical evaluation of its performance by an international panel of experts, who said that it could jeopardise the Nordic liver exchange scheme. Now doctors are worried that the publicity surrounding the closure will make people even more reluctant to register as donors.

The survival rate at the Aarhus unit, which was created in December 1992, was just 48% compared with a European average of 74%. This compares with a survival rate of 83% at Rigshospital in Copenhagen, where consultants described the Aarhus results as a "catastrophe."

Although local politicians were keen for Aarhus to get its own centre, many doctors opposed it on grounds that with a population as small as 5.2 million Danish expertise should be concentrated on one site. Denmark was divided into two transplant zones and at one point the National Health Board had to forbid the two from arguing in public.

Announcing the closure, the Danish health minister Torben Lund said that his decision was final: "We need to re-establish confidence because confidence in the donor

scheme has already been badly damaged by such a lengthy debate."

Only 100 000 Danes have registered their permission for their organs to be used after their death. In July, 283 people were waiting for kidneys, 10 for hearts, and 11 for livers. One leading transplant surgeon, Gosta Pettersson of Rigshospital, has urged that the law be changed to enable suitable organs to be used for transplant unless a person has specifically stated that they may not be.

Transplants in Aarhus were temporarily suspended in May, and the international panel of experts was asked to make a detailed study of the records of the 25 operations which had taken place. One of the members, Krister Hockerstedt from Helsinki, said that two of the livers were of such poor quality that they should never have been used for transplantation, while four of the patients were so ill that they should never have been operated on. He said that there was also an extremely high rate of complications, particularly of the gall bladder and blood vessels, in the patients who did survive.

The Aarhus doctors have maintained that they took a humanitarian approach towards patients who otherwise stood no chance and said that an earlier assessment, by a German team, had been favourable. Their attitude was strongly criticised by other hospitals participating in the Nordic organ exchange scheme, Scandia Transplant, which has a shortage of organs.

Professor Steen Linkaer Jensen, who heads the surgery department in Aarhus, said that he was "depressed and frustrated" by the closure. "Because of a political decision it was mandatory for us to accept high risk patients in whom one cannot expect the same survival rate. If we exclude them our survival rate was 67%." He said that the team had used organs of "marginal" quality only in

emergency situations where patients were close to death and it was their only hope of survival.—MARGARET DOLLEY, freelance journalist, Copenhagen

New day centre offers hope for "heartsink" patients

Britain's first specialised day service to treat difficult patients with long term neurotic disorders, often referred to by general practitioners as "heartsink" patients, has been opened in south London. The service, to be called the Cawley Centre, has been launched by the Bethlem and Maudsley NHS Trust and the Institute of Psychiatry.

The centre will provide treatment for patients who will typically have consulted general practitioners or local psychiatric

services for many years. These patients' treatment is characterised by frequent consultation and multiple referrals and investigations but lack of progress. The service will be offered free to local referrals and those from further afield as its funding is based on research conducted by the Institute of Psychiatry.

Peter Phillips, clinical nurse leader at the new centre, said: "By concentrating on a particular group of patients the centre is able to offer a highly specialised, multidisciplinary service. This will help patients to explore the deeper underlying sources of their problems, relieve pressures on general practitioners and other primary services, and provide a valuable teaching resource for health care professionals both locally and nationally."

The clinical director of the centre, Professor Anthony Mann, said: "The key to the service is that it is extremely flexible and tailored to the individual needs of each patient." He said that for some patients an afternoon spent at their general practitioner's surgery with staff from the centre might be sufficient to enable them to continue being

treated at primary care level. Others might require a four to six week assessment—as an inpatient if they live far from London—before a method of treatment could be proposed. He emphasised that the centre was not equipped to deal with psychotic, primary addictive, or violent patients. It was intended for people with chronic depression or anxiety.

Professor Mann said that heartsink patients had often already had numerous consultations with different professionals: "We don't want to be yet another of those. During an assessment period we do not offer any reassurance or any treatment. We simply listen, measure, watch, and gain trust."

Dr Bill Marson, a general practitioner who has already referred patients to Professor Mann, said: "It is terribly effective to have psychiatric intervention which essentially is an assessment. One learns about one's patients in a way that it would take hours and hours to do oneself. I also find that the patients themselves appreciate the opportunity to talk with a person who has not been too close to them over the years."—CLAUDIA COURT, *BMJ*

Focus: Washington

Health care reform is touch and go

For 30 years the US has been inching towards universal health care. As Congress finally edged up to the precipice last week it seemed to say, "No thanks. Not now. Maybe next year."

Last week the Senate began to debate a specific health care bill—itsself a major feat since no health reform bill has ever reached the full floor of either chamber. It was proposed by the majority leader, Senator George Mitchell, who had tried to amend a plan devised by a group of centrist Democrats and Republicans. That group has been the only real hope of a bipartisan compromise in seeking cost effective universal health care.

Mr Mitchell and his counterpart in the House of Representatives, Mr Richard Gephardt, said they would keep Congress in session until each house voted on its own bill—to the dismay of members of congress, who had planned to return home on 12 August to start campaigning for the November elections.

Further controversies were to follow. The Republicans threatened to filibuster. In the 100 member Senate a majority passes laws, but it takes 60 votes to stop a debate. The Democrats hold 56 seats, so the Republicans can virtually halt legislation by filibustering.

Nevertheless, the debate did get under way on Tuesday, though there was much partisan bickering. The Republicans accused the Democrats of robbing patients of choice

and money (through higher taxes); the Democrats accused the Republicans of robbing Americans of their only real chance of universal health care coverage.

Then Hillary Rodham Clinton entered the fray by pointing out that several Republican lawmakers had voted against Medicare in 1965. That law, which created universal coverage for the elderly, is one of Congress's unarguable successes. "And back then they called it 'socialised medicine,' just like they're calling our plan socialised medicine today," she said.

Just as the Senate got into its debate, however, the House of Representatives delivered a political blow to President Clinton—which most pundits say has put health reform in jeopardy. A liberal-conservative coalition killed the president's other initiative, a bill to fight crime. The result: debate of health reform in the house was suspended indefinitely.

Mr Clinton's poll ratings (and opinions of his health plan) have continued to fall. And now 23 of the biggest corporations, who have been strong supporters of health reform, have said the Mitchell bill is too costly to employers. (It would require employers and workers to split insurance costs 50:50 if more than 5% of Americans were still uninsured in 2000.)

Nevertheless, Ronald Reagan's ratings were once this low, and those moderate Republicans who worked out the initial compromise on health care are still willing to bargain. But no one knows whether health reform will pass this year. If it gets postponed

until after the November elections few believe it will pass in the next few years because the climax will have passed and the lawmakers will not have an agitated electorate to face soon.—JOHN ROBERTS

The legislative path is long and time is short