Chile stops controversial sterilisation

Chile has stopped the controversial use of quinacrine, an antimalarial drug, to sterilise women until its properties have been fully evaluated. The technique, which entails inserting quinacrine pellets into the uterus, works by scarring the fallopian tubes and was first developed by Chilean doctors. Health Minister Carlos Massad denied that the drug had been shown to have dangerous side effects but acknowledged that crucial tests relating to toxicity and mutagenicity had not been performed.

Health organisations and women's groups have argued for years that a double standard was being applied to women in the developing world who were given a drug that had never been approved for the purpose for which they were receiving it. Worldwide over 80 000 women have been sterilised with quinacrine in 15 countries, including Chile, India, China, Bangladesh, Costa Rica, Croatia, Pakistan, and Egypt.

The use of quinacrine for sterilisation was pioneered by a Chilean gynaecologist,

Jaime Zipper, in the early 1970s. At first the drug was given in slurry form, but this caused toxic convulsions, and was replaced by seven soluble granules inserted by an intrauterine device. The granules cause inflammation, and this leads to permanent sclerosis of the fallopian tubes.

According to a report by a toxicology panel of the World Health Organisation, the possible dangers associated with quinacrine used in this way include teratogenic risks, ectopic pregnancies in those women who are not successfully sterilised, liver and cardiovascular toxicity, and mutagenicity, since there is strong evidence that quinacrine is an intercalator of DNA.

Dr Ralph Heywood, a consultant in toxicology to the WHO, argued that use of the drug in sterilisation should be suspended immediately until a proper assessment had been made. "I'm not damning the drug," he said. "No one knows enough about it to do that, but the whole point is that no one knows enough to safely administer it either. It is a mutagen, and we've got to look at its genetic potential."

For supporters of the drug, though, the issue of risk benefit is less clear cut in the developing world. Dr Elion Kessel argued in the *Lancet* last September: "A simple guide to determining benefits is the estimate for

rural areas of developing countries that each sterilisation prevents two births. If maternal mortality is, say, 3.8 per 1000 live births as estimated for Vietnam, then each 1000 additional sterilisations done by a new method such as quinacrine pellets will prevent 7.6 maternal deaths. No one has suggested that the method could kill that number of women."

Opponents of this view say that it is quite unscientific to compare a method of sterilisation with the risks of maternity; rather it should be compared against other sterilisation techniques. Nor does the introduction of quinacrine necessarily lead to more sterilisations—it could lead to the government saving money. It is the low cost of quinacrine and the ease with which it can be given that make it so attractive.—OWEN DYER, freelance journalist, London

Correction

Israel introduces national health insurance system

An editorial error occurred in the conversion of shekels to pounds in the news article by Judy Siegel-Itzkovitch (28 January, pp 212-3). One shekel is worth about 20p, not 50p as assumed in the article.

Focus: London

Doctors in management: big budgets and difficult colleagues

For a long time medicine has been unlike many other professions in that you have not had to stop practising in order to get on.

Nurses in particular complain that to advance professionally they have to abandon the bedside and become managers. In medicine rather the opposite has applied: many leaders of the profession have gained and retained that leadership because of their clinical strengths.

The desire to retain that combination of clinical strength and leadership was an underlying theme at last week's conference "Every doctor is a manager," run by the BMA, *BMJ*, and the British Association of Medical Managers. Just as Molière's Monsieur Jourdain discovered that he had been speaking prose all his life without realising it, so doctors are gradually realising that in practice they are all managers (of their own time, junior staff, colleagues, their practices, health service resources). But the changes in the NHS are also throwing up more formal requirements for management—as medical directors, clinical directors, and fundholding partners. It is clear that the attractions of these roles are only for the committed. And it was largely the

committed who came to the conference.

It was the very committed whom they listened to. Cyril Chantler, who helped establish one of the early examples of clinical management at Guy's Hospital, London, spoke strongly of doctors' responsibility to get involved in managing the service. He wanted them involved at all levels, but he was clear too that clinical directors had to sit at management board level and make the important decisions. Anything less, he said, reminded him of a manager's cynical comment that all you needed to do with consultants was "make them clinical directors, teach them how to count, and then they make the cuts."

Peter Jackson, a consultant obstetrician and clinical director in Huddersfield, spoke too of the reasons why some clinical directorates had failed. He thought that 80% of the job was communication—a view endorsed by one of the management experts at the conference—but the remaining 20% had to be creative. Those directorates that had failed had done so because the directors got bogged down in paperwork.

A clear need was for better training for medical managers. Graham Winyard, medical director of the NHS Executive, pointed out that doctors' problems in being suddenly thrust from nowhere into managing big budgets and many people were compound-

ed by the fact that they then only did three years in the job. "As soon as they begin to understand management, they are moved on." One solution was to start building careers in medical management and start recruiting from outside the hospital. But for many medical managers the big issue is retaining their clinical skills.

Most clinical directors believe that clinical directors need to retain clinical sessions—partly to retain credibility among their clinical colleagues. That clearly carries its own burdens—and not just in workload. Peter Jackson told of the day when he was on his way to tell parents that their daughter had cancer of the ovary when he was bearded by an irate colleague complaining about car parking. Retaining credibility is important partly because clinical directors do not manage their consultant colleagues in the way that other managers do, through line responsibility. That demands considerable skill because they need to work through consultation and consent (and it is probably not a bad way to manage anyway), but line management among doctors is an issue that is fudged in directorates.

If, as the feeling of the conference seemed to be, that it is time to get serious about doctors managing it is an issue that may not be able to be fudged for much longer.—JANE SMITH