Girl with leukaemia will be treated privately

A 10 year old girl with leukaemia who last week was at the centre of a dramatic court battle over her health authority's refusal to fund last chance treatment is this week being treated at a private hospital after an anonymous donor came forward. The girl, named only as B, is undergoing chemotherapy and, if that works, will be given a bone marrow transplant. She is being treated by Dr Peter Gravett, a haematologist at the private Portland Hospital in London. The £75 000 cost will be met by the unnamed benefactor, who made the offer after the family lost its battle in the Appeal Court.

B's father sought a judicial review of Cambridge Health Authority's decision not to pay for the treatment. Doctors at Addenbrooke's Hospital in Cambridge and the Royal Marsden Hospital in London had advised against it, saying that it would cause her suffering and had only a 2.5% chance of success. She had already been given one bone marrow transplant at the Royal Marsden Hospital last year, with her 9 year old sister as the donor.

The girl, who was unaware of her condition and the legal battle, has been brought up by her father since her mother left when she was 2. Her father gave up his job to care for her. Dr Gravett said before beginning the treatment that the girl must be informed about the chances of success, which he puts at 10% for the chemotherapy and, if that succeeds, 10% for the transplant.

B developed non-Hodgkin's lymphoma when she was 5 and had chemotherapy at Addenbrooke's Hospital. Last year she was diagnosed as suffering from acute myeloid leukaemia and received the first bone marrow transplant. In January she was given six to eight weeks to live, and on 27 February the health authority told her father that it could not justify another transplant.

Last Friday in the High Court Mr Justice Laws quashed the health authority's decision and ordered it to reconsider. He said: "Where the question is whether the life of a 10 year old child might be saved, by however slim a chance, the responsible authority must in my judgment do more than toll the bell of tight resources."

But the health authority immediately appealed. After a four hour hearing the Appeal Court, led by Sir Thomas Bingham, master of the rolls, overturned the earlier ruling. Sir Thomas said: "While I have every sympathy with B, I feel bound to regard this as an attempt, wholly under-

Mr Justice Laws criticised the health authority for tolling the bell of tight resources

standable but nevertheless misguided, to involve the court in a field of activity where it is not fitted to make a decision favourable to the patient." The Appeal Court's judgment reaffirms the courts' reluctance, shown in other cases, to interfere with health authorities' and trusts' use of resources.

The "fundamental right to life" of the child—a phrase invoked by Mr Justice Laws—has never before been cited in this type of case. Had the High Court's judgment stood, it could have opened the way for others to try their luck in the courts after being refused treatment because the cost outweighed the likely benefit. Other cases have included unsuccessful attempts by parents of babies with defective hearts to speed up their children's operations and the challenge two years ago by the parents of Rhys Daniels, a 2 year old boy with Batten's disease, of the decision to close the only specialist unit offering him treatment. In that case the High Court judges criticised the way that the decision to close the unit had been taken but refused, since another hospital had intervened to offer treatment, formally to declare it unlawful.—CLARE DYER, legal correspondent, *BMJ*

Consultants should be checked up on, says commission

Consultants in Britain should be monitored for their attendance at outpatient clinics and operating theatres, said the Audit Commission this week. It said that though most consultants "need have nothing to fear from such monitoring," the data could be used in disciplinary procedures.

The commission surveyed 11 hospitals and sent questionnaires on working practices to 1100 doctors, of whom 655 responded. Its report finds that private work is done at the expense of NHS commitments: the quarter of doctors who do most private practice carry out less NHS work than their colleagues.

"If anything the results are likely to be an underestimate of the trade off between NHS and private work," warns the report. "For those so inclined, it is easier and less visible to find the time for private practice by cutting back on aspects of NHS responsibilities other than operating sessions."

Headlines

Appeal launched for Palestinian health sector: The World Health Organisation has launched a \$13m (£8.6m) appeal "to provide funds for meeting the urgent health needs of the Palestinian people." The WHO has had a programme of technical help in the West Bank and Gaza Strip since 1985.

US president wins support for Medicare cuts: The US House of Representatives' ways and means committee has approved President Clinton's plan to save \$10.5bn (£7000m) in Medicare over five years.

British parliament studies alcohol and crime: An all party group of the British parliament is to investigate the links between alcohol and crime. Government statistics show that 60-70% of murders, 75% of stabings, and 70% of beatings are related to drink.

British MPs try to tighten abortion law: The cross party group of pro-life MPs wants to tighten the abortion law by amendments to the Abortion Act to prevent fetuses being subjected to pain and to stop embryos being stored for long periods.

£1m allocated to childbirth projects: The British Department of Health is inviting bids for the second wave of projects on "changing childbirth" and is making £1m available for developments in consumer involvement, integrated education, and models of service delivery.

Too many Britons are overweight: The Office of Population Censuses and Surveys says that 44% of men and 32% of women aged 16 and over are overweight. Only one in 10 adults is free of the modifiable risk factors for cardiovascular disease—smoking, raised blood pressure, raised cholesterol concentration, and lack of physical activity.

Charter flights ban smoking: The seven largest charter airlines, which account for 95% of all charter seats, are to ban smoking on flights of under six hours from 1 November. This affects 90% of holiday routes.

US moves to prevent spread of tuberculosis during air travel: The US Centers for Disease Control says that people known to have active infectious tuberculosis should not travel on commercial flights.

Since 1991, district health authorities and trusts have been responsible for agreeing job plans with consultants that detail their fixed commitments. The commission found that some hospitals did not have job plans and that where such plans existed they were not monitored. The commission surveyed 43 consultants' attendance in operating theatres and outpatient clinics and found that only just over half attended all their fixed commitments. Non-attendance due to leave or cancellation outside the consultants' control was not included in the analysis.

The report is critical of the way in which doctors work. There are 55 000 doctors in British hospitals, who account for £2000m of NHS expenditure. But while the demands of the service have changed—patients spend less time in hospital and require more care during that time—doctors have not changed their work patterns. "Despite some broadening of firms and sharing of junior doctors, many consultants still practise as individuals rather than as part of a team and the roles of junior grades and the culture of the medical hierarchy remain essentially the same," says the report. "Doctors' working arrangements have not adapted fast enough to the rapidly changing environment in which they work."

The commission argues that "the number and mix of staff are more related to custom and practice than to the needs of either patient care or medical training." It says that junior doctors should have job descriptions and guidelines on who should do what tasks. In some hospitals senior house officers were carrying out most of the operating sessions without senior staff, and overall they ran one in five outpatient clinics.

The report is clear that teams are preferable to firms—workload can be spread more fairly, and juniors can have better access to consultants at all times. It says that shift work is more effective for providing emergency cover and that senior doctors should be present at busy on call periods such as late morning and evening. "The most junior

staff are usually first on the scene in emergencies and sometimes have too much responsibility given their level of training," it says.

Postgraduate deans, who are now responsible for half the training budgets of junior doctors, are urged to improve careers advice and, with the royal colleges and trusts, develop structured training. The report finds that while 85% of consultants said that they assessed their junior staff, fewer than half of the junior doctors said that this was the case.

The report calls on the Department of Health to produce guidance on the skill mix of doctors, review the need for national controls on training grades, and increase part time posts.—LUISA DILLNER, *BMJ*

The Doctors' Tale is available from HMSO bookshops, price £12.

Bed register could be set up after patient's death

Changes to the allocation of emergency beds are likely in London after the death of a patient who was flown 320 km for neurosurgical treatment. Malcolm Murray, 45, had severe head injuries and was transferred from Kent to Leeds after a telephone search failed to find a bed in south east Britain.

Philip van Hille, a consultant neurosurgeon at Leeds General Infirmary, operated on Mr Murray at 8 am on 8 March, 10 hours after Mr Murray was hit by a van outside a pub in Orpington. When Mr Murray died eight hours later Mr Van Hille said, "a delay like that does not do any good at all." The furore soon reached the House of Commons, with Labour accusing the government of closing beds in London that

RAF helicopters are often used to transfer NHS patients

ADAMS PICTURE LIBRARY

could have saved the patient's life. John Horam, the new citizen's charter minister, was told by junior health minister Tom Sackville that the hour's journey in the helicopter could have worsened the patient's condition.

The exact story of the search for a bed remains unclear, but both Queen Mary's Hospital in Sidcup, which first admitted the injured man, and South Thames Regional Health Authority have launched urgent inquiries into the events that followed Mr Murray's accident. Initial reports suggested that one junior doctor, armed only with the booklet *Guide to Emergency Care Centres of Britain*, had telephoned nine hospitals in the south east before turning to Leeds. London's *Evening Standard* newspaper claimed to have interviewed "insiders" at Queen Mary's, who said that the hunt for a bed involved several junior and senior doctors.

A source claimed that no fewer than 25 hospitals had been approached. A spokesperson for Queen Mary's Hospital insisted that doctors called the Royal London Hospital. A spokeswoman for the Royal London denied that any request had been received: "If they did call they certainly didn't speak to the neurosurgical registrar, who was the appropriate person. I have no evidence that they contacted anyone else here either."

The London Emergency Bed Service does have a record of a call from Queen Mary's Hospital, which came at 2.35 am, but the note refers to a general inquiry about the availability of intensive care beds. According to Graham Hayter, director of the service, no specific patient was mentioned, and the service never realised that it was dealing with a real emergency. "In any case," he said, "our role is marginal in this sort of thing. We can compel hospitals to provide emergency beds for GP referrals, but we have no equivalent mechanism for interhospital transfers."

Mr Hayter is more surprised that staff at the Brook General Hospital in Woolwich, the first to be called by Queen Mary's Hospital, did not assist in the search. "They are part of the neurosurgical network, which Queen Mary's is not," he said. A senior neurosurgical registrar at the Brook advised the Queen Mary's doctors on how to treat Mr Murray, but the neurological ward there was closed because of an outbreak of gastric flu.

Eventually a bed was found at Leeds and a Royal Air Force helicopter was called from Wattisham, Suffolk. The Royal London's helicopter was closer but does not fly at night for safety reasons.

Emergency helicopter flights are not uncommon in the NHS. The Royal Air Force carried 205 patients for the NHS last year and has carried 1488 since 1990, at a cost to the health service of about £30m.

A partial solution would be an up to date computerised register of available beds, and the London Emergency Bed Service plans to introduce one. "We already have a register of neonatal care cots," said Hayter, "and we'll be extending it in the near future."

—OWEN DYER, freelance journalist, London

Glaxo—its take over of Wellcome has made it the largest drug company in the world

Glaxo take over creates largest drug company

Last week, as a result of Glaxo taking over Wellcome, Britain became home to the world's largest drug company—Glaxo Wellcome—but thousands of jobs are likely to be lost in the pharmaceutical industry as a result.

The failure of a potential "white knight," rumoured to be Zeneca, to persuade the Wellcome Trust to accept a counter offer for its Wellcome shares left the way clear for the hostile takeover. Wellcome's board was left with no option but to recommend that shareholders should accept the offer put forward by Sir Richard Sykes, chief executive of Glaxo, of £10.49 a share. With £500m to be paid in share options for employees, this brings the total price to £9.4bn. Wellcome had claimed that the potential white knight was prepared to better this price by about £500m, but the rescue effort was scuppered by the Wellcome Trust. In January the trust shocked Wellcome's directors by promising to sell its 39.5% stake in the company to Glaxo despite a gentleman's agreement in 1992 that it would hold the shares for at least five years.

The trust's legal advisers may have warned against acceptance of the white knight's offer because the bidder demanded assurances that the counter offer would have a high chance of success. In other words, if Glaxo then raised its bid, as it had signalled its readiness to do, the trust would not

accept. This might have breached trust law, which enforces a duty on trusts to maximise their income. It might also have run counter to a clause in January's agreement between Glaxo and the trust, which stipulated that the trust would not "enter into any agreement...which would or might restrict [the trust's] rights to dispose of the shares pursuant to the offer."

Other shareholders in Wellcome and the Wellcome board itself will be furious if they find that the trust denied them an extra £500m by binding itself to an agreement that scared off other bidders. The *Times* commented: "Memo to investors: don't trust a charitable trust any more than any other controlling shareholder. There is nothing like a good cause to justify behaviour open to question in ordinary mortals." Zeneca was in any case ill placed to digest Wellcome, being a smaller company in terms of sales and only about one quarter the size of Glaxo.

The world is also likely to have a new third biggest drug company soon, as the German firm Hoechst is in negotiations with Marion Merrell Dow and the Dow Chemical Group about possible mergers.

—OWEN DYER, freelance journalist, London

The top five companies in 1994 by sales were:

Merck and Co (US): \$8.8m (£5.9m)
Glaxo (UK): \$8.5m (£5.7m)
Bristol-Myers Squibb (US): \$6.5m (£4.4m)
Hoechst (Germany): \$6.0m (£4.0m)
Roche (Switzerland): \$5.3m (£3.5m)

Professor banned from transfusion building

A professor of transfusion medicine at the University of Cambridge, the first in its history, has been banned from entering the blood transfusion building in the grounds of Addenbrooke's Hospital. Jean-Pierre Allain is confined to an office in the nearby department of haematology, apparently because of his conviction in France for having distributed blood that was contaminated with HIV. Professor Allain recently served a two year sentence for the offence.

The National Blood Authority and the Department of Health have refused to comment on the ban except to say that Professor Allain is not employed by the NHS and therefore has no reason to enter the transfusion building. Colleagues in the blood transfusion service, however, say that scientific meetings have had to be rearranged and held at the nearby maternity hospital so that Professor Allain can talk and listen to colleagues.

Professor Allain has also refused to comment in detail on the ban except to say that his situation is "undefined" at present. "The subject is a bone of contention between the university and the transfusion service," he said. Professor Robin Carrell, head of the department of haematology, said that the position was delicate because of the need to differentiate between Professor Allain's university position as professor of transfusion medicine and his health service role.

Cambridge University originally intended that Professor Allain's academic position should be unpaid and that his salary would come from the Department of Health because of his post as director of the East Anglian Regional Blood Transfusion Service. But since Professor Allain's conviction in 1992 the blood transfusion service has been reorganised and he has effectively had this health service post taken away from him. As a result Cambridge has had to find his professorial salary of £37 000. Questions are now being raised about whether a professor of transfusion medicine can conduct research without having access to patients or the transfusion service.

Professor Allain has received considerable support from some senior British academics, notably the vice chancellor of Cambridge University, Sir David Williams. Sir David believes that Professor Allain has been made a scapegoat by the French authorities and that he is innocent. Sir David, a lawyer, said that the circumstances of his trial were exceptional and unprecedented.

But the political risks of having Professor Allain come into contact with British patients seem too much for the Department of Health to contemplate. Professor Allain's conviction for distributing contaminated blood stems back to 1985, when the full extent of the AIDS epidemic was only just beginning to be realised. He said that he had warned his superiors of the risk of distribut-

Professor Allain: seen by some as a scapegoat

ing blood products that had not been heat treated but that his warnings were not heeded. He was sentenced to four years' imprisonment, with two suspended, in October 1992 for his role in the infection of hundreds of French haemophilic patients with HIV in 1985. He was then head of research at the National Centre for Blood Transfusion in Paris. All the time he was in prison his salary in Britain was paid, initially by the NHS and then by the University of Cambridge.—STEVE CONNOR, science correspondent, *Independent*

Medical editor in US criticised for legal work

The work that the editor of an American medical journal did for lawyers who were defending the makers of breast implants did not bias his handling of articles about the controversy over silicone implants, although it was "not prudent," an investigation concluded last week. The review said, however, that Dr Peter Schur, editor of *Arthritis and Rheumatism*, should have stepped aside from judging articles on breast implants for the journal and should have told the journal's owner, the American College of Rheumatology, about his financial ties with the lawyers.

The journal's publications committee started the investigation last December after an article by Associated Press disclosed that Dr Schur worked as a consultant and expert

witness for law firms representing manufacturers of implants in suits brought by women. In the US rheumatologists commonly treat women with complaints that have been attributed to silicone implants.

Researchers debate whether implants cause health problems. But, without admitting wrongdoing, manufacturers have agreed to pay £2.7bn (£1800m) to settle lawsuits brought by women with the implants.

Dr Schur, whose five year term as editor ends in June, declined to comment on the investigation. A separate inquiry is being carried out at his hospital, Brigham and Women's Hospital in Boston.

"We found that despite the potential conflict of interest, there was no manipulation or distortion" of research into breast implants submitted for publication in the journal, Dr David A Fox of the University of Michigan, the committee's chairman, told the Associated Press. Dr Fox said, however, that once Dr Schur began testifying "it would have been preferable [for him] not to have been involved in the review of articles on that topic."

The committee called it "risky" for the editor to appear to be a crusader. "The extent of Dr Schur's work as an expert in litigation was viewed by the publications committee as not prudent for the editor of *Arthritis and Rheumatism*, who is expected to maintain (and foster the appearance of) an evenhanded approach," the committee's report concluded.

The committee also criticised Dr Schur for failing to mention his consulting work, which began in 1993, on a form asking about conflicts of interest in October 1994.

It said that Dr Schur, who had written in the journal that evidence against silicone implants was insufficient to prove cause, apparently did not regard his legal work as important, and "this rather naive and misinformed approach is regrettable." Dr Schur gave up his consulting last year soon after the Associated Press's article appeared.

Dr Marcia Angell, deputy editor of the *New England Journal of Medicine*, told the press that the affair highlighted the need for journals to have strong policies against conflicts of interest. "I see no evidence that Dr Schur was biased, either as a scientist or as an editor, but no one should have to wonder about this," Dr Angell said. "An editor is like a judge who is called on to make objective evaluations and cannot have financial connections with lawyers of the businesses involved in cases."—JOHN ROBERTS, North American editor, *BMJ*

Search for HIV vaccine faces setback

Researchers trying to develop a vaccine against HIV faced another setback last week. An analysis of the nucleotide sequences of more than 100 AIDS viruses showed that a surprising number—nearly a tenth—were hybrids that had resulted from genetic recombination between two different strains of HIV infecting the same person. For researchers it means that the virus has yet another means of generating the genetic variation that has become archetypal of this human pathogen.

Scientists from Britain and the US, who published their findings in *Nature*, have investigated 114 viral sequences from all eight major subtypes of HIV from around the world.

At least 10 of the viruses had "mosaic" sequences representing a hybrid virus that had evolved within a single patient infected by two distinct strains of HIV. All eight subtypes had been found to contain hybrids, clearly showing that the phenomenon was a universal problem that involved one virus swapping its genes with those of another infecting the same human cell.

Only a year ago such recombination was thought to be so unlikely as to be practically impossible. The researchers believe, however, that coinfection with two or more strains of HIV is almost certainly underestimated by their findings "since recombinants of divergent viruses from the same sequence subtype are much more difficult to detect."

The research team, drawn from Nottingham University; the Walter Reed Army Institute of Research in Rockville, Maryland; and the University of Alabama at Birmingham, said that the findings emphasise the importance of looking for hybrid HIV strains in countries such as Thailand where vaccine programmes are planned.

"The surprisingly high frequency of mosaic HIV-1 sequences in the database

implies that a substantial proportion of individuals can become coinfecting with HIV-1 strains belonging to different sequence subtypes, and that recombination between these genomes can occur in vivo to generate biologically active viruses."

The researchers added: "These results raise pressing questions concerning global frequency of such recombinants, their biological significance, and their impact on vaccine design and development. They prompt investigation of the circumstances under which coinfection (either by simultaneous transmission of divergent viruses, or by successive superinfection) can occur."

One of the more intriguing and potentially worrying aspects of hybrid strains is that they could result in the evolution of a type of HIV that possesses significantly greater pathogenic qualities, such as higher transmissibility.

Professor Paul Sharp, professor of genetics at Nottingham University, said that this was one of the great unknowns at present. "I would not want to create a scare, but this ability to create hybrids gives you an evolutionary jump and we don't know what the properties of a hybrid may be."

The ability to recombine within human cells, he said, "is another worrying complication" to the already diverse nature of the virus.

Genetic recombination in other viruses has been known to make them dangerous. For instance, scientists have shown that two non-pathogenic strains of herpes virus can produce a pathogenic hybrid that can kill laboratory mice. Similarly, far more virulent flu viruses can come about after recombination between two relatively non-pathogenic forms.—STEVE CONNOR, science correspondent, *Independent*

Irish women win right to information on abortion

Doctors in the Republic of Ireland can now provide women patients with the names and addresses of abortion clinics in Britain after votes in the Dail and the Seanad gave legal effect to the 1992 referendum that approved the proposal. The bill stops short of authorising direct referrals by general practitioners. A government spokesperson said that this was because of a written commitment not to do so given by the then government, which had been led by Fianna Fail, before the referendum. The decision was also influenced by British law, which requires British medical approval for a termination.

The Irish Family Planning Association has been making referrals for three years after obtaining legal advice. This maintained its commercial link with the British Pregnancy Advisory Service, an organisation providing abortions legally in another member state and thus protected under European competition law. The Irish Family Planning Association is among the organisations now urging the Irish president, Mrs Mary Robinson, to refer the bill to the Supreme Court to test its constitutional standing in the light of the vote in 1992. Ministers have said that, if the bill is constitutional, future antiabortion legal challenges on this issue will be blocked.

Moving the Regulation of Information Bill in the Dail, the health minister, Mr Michael Noonan, condemned intimidation of Dail MPs by antiabortion groups and pressure from a High Court judge who had

The Irish government has decided that doctors can give information on abortion clinics in Britain

equated abortion with the Nazi holocaust. Both the health minister and his predecessor, Brendan Howlin, have had their homes and constituency surgeries picketed by the radical Irish antiabortion Youth Defence Group, which claims 4000 members.

The decision of the main Fianna Fail opposition to oppose the bill on first reading publicly split the party. Donegal Fianna Fail MP and general practitioner, Dr Jim McDaid, accepted the party whip and voted against the bill but only after saying, "As a doctor I would find great difficulty saying to a girl who insisted on a termination even after all the advice available, 'I am sorry, I can no longer help you, but there is a boat at Dun Laoghaire.'" He admitted that he was a hypocrite. He quoted from a letter threatening that his house would be picketed and his practice boycotted.

Among fellow dissidents was his party's finance spokesman, Charlie McCreevy, who cited the recent pregnancy of an 11 year old Cork girl after she was raped by a 51 year old man. "Real life would not go into hibernation," he warned, while critical issues had to be decided.

Ireland's Catholic hierarchy effectively left voters with a free choice on the abortion question in 1992 but this month warned that those giving information on abortion would be "participating in the violation ... of a child's right to life." Last week the

Archbishop of Dublin, Desmond Connell, claimed that it was "incorrect and misleading" to say that the bill was simply about information. He said that it involved assisting in the procuring of abortions.—ALAN MURDOCH, freelance journalist, Dublin

Chemical weapons did not cause the Gulf war syndrome

The United States Defense Department believes that no evidence implicates chemical or biological weapons as causes of the illnesses suffered by veterans of the Gulf war, even though many of the illnesses cannot be diagnosed. Testifying to Congress, Dr Stephen Joseph, assistant secretary of defence for health affairs, said, "There is no one unique, single, overriding cause" of the illnesses that have come to be known as the Gulf war syndrome.

Dr Joseph said that a cause could be found for symptoms in 84% of veterans reporting health problems. In 2074 cases analysed, about 4% of the veterans were suffering from infectious diseases while 21% had psychological problems, he said. About

15 000 veterans are taking part in the Pentagon's comprehensive clinical evaluation programme, and doctors were unable to make a diagnosis in about 16% in the study who complained of fatigue, headache, and sleep disturbances.

Dr Joseph discounted arguments that Iraqi chemical or biological agents could have made the soldiers ill, repeating the Pentagon's assertion that "there is no persuasive evidence of such exposure even after much scrutiny." But he insisted that "we are very determined not to foreclose any possibilities."

The American Legion, a veterans' group, said in a statement that the figure for undiagnosed cases should be closer to 40%. The group said that the head of the Walter Reed Army Medical Center had stated that, as well as the 16% cited by Dr Joseph, an additional 25% seemed to have the chronic fatigue syndrome.

Preliminary studies show that mortality among Gulf veterans is no higher than that in a matched population of Americans.

President Clinton said last week that he would set up an independent advisory committee to oversee the many government programmes studying health issues related to the Gulf war. The Institute of Medicine is also investigating the health problems of Gulf war veterans.—JOHN ROBERTS, North American editor, *BMJ*

Focus: Westminster

The politics of a cradle to grave NHS

National Health Service provision from "cradle to grave" has been a popular commitment by British politicians, from Winston Churchill onwards, for the

past 50 years. It is also a definition from which they are reluctant to retreat. The modern version, cited by health minister John Bowis last week, is that state health care "starts before the cradle, but cannot go beyond the grave." The point at issue nowadays is how far short of the grave should it stop?

Mr Bowis was giving evidence to the Commons health committee after the publication of new guidance on NHS responsibility for continuing care (4 March, p 550). The guidance is intended to deflect criticism that the NHS is defaulting in its duty of long term care, particularly of very elderly people.

In that respect the document is something of a landmark. It admits current shortcomings and also commands the health service to reinvest in a "full range" of long term care facilities. These can now be expected to absorb a significant share of NHS growth in

coming years. The guidance also clarifies who will be entitled to continuing care: here the new rule of thumb is that the patient should require consultant supervision at least weekly.

In reasserting NHS responsibilities for long term care ministers deny that there has been any policy shift in the boundary between health care and social care which has existed since 1948—though demography dictates that far more people now come into the latter category. Since NHS care is free and social care is means tested it matters to patients and their families where they end up. Should people needing nursing supervision 24 hours a day get it on the NHS? Last week the MPs seemed to think so, but the minister said not unless they also needed medical care. The new guidance probably takes the NHS as far as it is obliged to go, short of becoming a nursing home service. It still falls short, however, of what taxpayers expect.

It is the discrepancy between free and means tested care that the political parties hesitate to address. The health committee now has the opportunity to give a lead. The most clear headed statement so far came from Labour's social justice commission last year. It conceded that the NHS cannot be expected to provide care and help with

everyday activities and that means testing is reasonable even at the cost of the next generation's inheritance. Not surprisingly, that finding is quoted more often by Tories than by Labour.

Meanwhile the prime minister, John Major, wants new Tory thinking on the issue in time for the next election. Early ideas point to easing the impact of means tested care for elderly people, perhaps by leaving the value of their home out of the assessment. If the state does move to protect inheritances in this way it could, after all, be said to be offering care beyond the grave.

And what about the cradle? As it happens, a simultaneous meeting at the Commons was gloomily contemplating the government's U turn on the advertising of baby milk. Having proposed a ban on promoting infant formulas, the government last month changed its mind and allowed the continuing promotion of formulas in NHS premises.

Midwives, paediatricians, and breast feeding campaigners met Labour front bench spokesman Martyn Jones to plan a counterattack. The government remains deaf to persuasion, but the campaigners did not come away empty handed: it is now Labour party policy that baby milk should not be promoted.—JACK WARDEN, *BMJ*