Russia hit by infectious diseases

Russia and the other countries of the former Soviet Union are seeing a sharp increase in the incidence of infectious diseases as poverty and the breakdown of the communist health care system take their toll. Diphtheria and tuberculosis are the main threats, although the incidence of cholera and sexually transmitted diseases is also rising. According to figures from the State Committee for Sanitary and Epidemiological Supervision, the overall incidence of infectious diseases rose by 180% in 1994. This was after a sharp 290% increase in the previous year.

Fighting in the region of Chechnya, which is feared to have claimed at least 25 000 lives over the past three months, has added a new danger. Doctors in the capital, Grozny, where some 100 000 people currently live without running water, gas, or electricity, are bracing themselves for an epidemic of cholera and other diseases as temperatures rise during spring.

Water in the city is supplied from trucks but has to be boiled over fires of wood. Makeshift graves, often dangerously shallow, dot the roadsides, while more bodies are trapped in the rubble. "The sanitary and epidemiological situation in Chechnya is close to an emergency," said Yevgeny Bolyayev, head of Russia's Epidemics and Sanitary Control State Committee.

Yuri Fyodorov, the deputy chief of the Russian Health Ministry's infectious diseases department, has cited other potential dangers in Chechnya: diphtheria has claimed several victims in recent weeks, while hepatitis and dysentery are widespread. Health officials claim that the problem has been exacerbated by the collapse of state public health services during the three years of self proclaimed independence in Chechnya. Russian troops were sent in to end this state of independence.

Vaccination programmes virtually ground to a halt during the period, while epidemiologists from elsewhere in Russia were barred from visiting the region. But Chechnya is far from being the only black spot in the former Soviet Union: the danger of epidemics is also acute in several other regions.

South of the Caucasus in the Georgian capital, Tbilisi, officials have warned of the dangers of cholera because of a deterioration in the quality of the city's water supply system, which has not been properly renovated in more than half a century. Malaria is also emerging as a danger in the Krasnodar region and elsewhere across southern Russia.

On Russia's Pacific Coast, it is diphtheria

Chechnya: fighting is not the only health hazard

that is the main problem. The incidence of the disease last year in the bleak Magadan district was 93 per 100 000 population, more than four times the national average.

The situation seems to have worsened this year. Epidemiologists in the nearby Khabarovsk region registered 50 cases of diphtheria in two small towns, Sovetskaya Gavan and Vadino, in January, against 317 in the whole region last year.—PETER CONRADI, Moscow correspondent, *European*

Bosnian doctors fax for food

An urgent appeal for help for doctors in Bosnia was made last week at a joint meeting in London of the World Health Organisation and the European Forum of National Medical Associations. In a faxed message saying that its representatives could not attend because Sarajevo airport had closed, the Bosnian Medical Association said, "We acknowledge that it's impossible for our fellow national medical associations to pay our salaries, but we appeal to the forum for food aid for doctors working in Bosnia."

The impassioned appeal was a stark reminder to the meeting that the problems facing doctors in central and eastern Europe

are of a different order to those in the west. "Eight countries are at war in Europe," said Dr Jo Asvall, WHO regional director for Europe, "and in former Yugoslavia alone there are four million refugees. Inequity in health has been widening steadily in the past few years. For example, the average life span in Russia is now only 59 years."

Political and economic unrest is challenging health care reforms in central and eastern Europe, and the low status and morale of doctors in some countries do not encourage them to take part in improving their health services. "Our association is now four years old, and, although we are making progress, doctors here are very disenchanted with medicine. They get little support from the public or the government, and with the same salary as factory cleaners it is unsurprising some leave," said Dr Albert Andrev, president of the Russian Medical Association.

"Our problem," said Dr Rytis Virbalis of the Lithuanian Medical Association, "is that we have a government that does not even recognise health care as a priority. For us it is very important to have a consensus statement that underlines the key role that medical associations have in changing health care systems and shaping future policy. Politicians take more notice of our views if we have a pan-European mandate to do this." (See also p 876.)

"In Romania the government has been

Measles cases drop by 90%: Cases of measles in England and Wales fell by 90% in January and February compared with the previous two months because of the immunisation campaign, said the government this week. The campaign cost £20m and was offered to all children aged 5-16. Over 90% were immunised.

British ambulance workers reject 1% offer: Leaders of Britain's 25 000 ambulancemen have rejected a 1% national pay offer and will join other health service workers in a day of protest on 30 March. Unlike nurses, ambulance staff, who earn an average of £14 000 a year, have not been given an indication that local deals will increase the offer to between 0.5% and 2%.

US National Institutes of Health cleared in drug trial: A panel set up by the US Institute of Medicine has said that the deaths of five patients in a test of an experimental drug to treat hepatitis B were not the result of mistakes made by researchers at the National Institutes of Health. The researchers had halted the trial as soon as they found that fialuridine was causing liver damage.

British heart surgeon cleared of bribery allegations: Mr Unnikrishnar US Nair, a heart surgeon at Killingbeck Hospital, Leeds, has been cleared of allegations that he accepted money to move a patient up a NHS list after a three month police investigation. He is considering suing.

US House of Representatives approves welfare cuts: The US House of Representatives has passed a radical welfare reform bill which cuts \$66bn (£41bn) off welfare spending over the next five years and abolishes the principle of welfare entitlement for able bodied recipients who refuse to work. The bill scraps several federal programmes and sends the money to the states in the form of grants, allowing them to create their own social security safety nets.

NHS fraud trial halted: A fraud trial estimated to have cost taxpayers over £4m, has been scrapped for the second time after a judge threw out the charges against three men accused of milking £400 000 from the NHS. It was alleged that money supposedly spent on equipment and staff was used for family holidays and trips to rugby internationals.

Queuing for food in Bosnia

very selective in the topics on which it has sought our advice," said Dr Radu Dop, vice president of the Romanian Medical Association. "We are now very worried about a new threat to our professional independence. In three weeks' time a bill is going to be passed in parliament to promote a new national medical association to work with it more closely. All doctors are going to be forced to join it—otherwise, their right to practise will be withdrawn."

Despite behind the scenes discussions on how best to respond to the Bosnian plea, the three day meeting closed without the WHO or national medical associations agreeing on any practical response. But the meeting did issue a supportive statement. Dr Otmar Kloiber, of the German Bundesärztekammer (the German medical association) said, "It's a pity we did no more. If I was a doctor in Bosnia I'm not sure how much comfort I would derive from good words."—TESSA RICHARDS, BMJ

Northern Ireland MPs fight abortion

Members of parliament from all Northern Ireland's political parties represented at Westminster are to oppose any attempt to extend the 1967 Abortion Act to the province. This is despite a commission's recent conclusion that abortion law there is so uncertain as to be unable to withstand a challenge before the European Court of Human Rights.

The law in Northern Ireland, based on the 1861 Offences Against the Person Act and the 1945 Criminal Justice (Northern Ireland) Act, allows a termination after 28 weeks when there is a grave risk to the life or health of the woman or there is an

abnormality of the fetus. The law is unclear on terminations before 28 weeks.

Labour MP Harry Barnes has put down a Commons motion claiming that the difference in the law between Northern Ireland and Britain is discriminatory and causes unnecessary suffering to women in Northern Ireland. He is urging a common abortion policy for Britain and Northern Ireland. This follows recommendations from the Standing Advisory Commission on Human Rights urging the British government to move to clarify the law and to collate information about abortion practice in the province.

In response Unionist and Social Democratic Labour party MPs have backed an amendment to the Barnes motion from Conservative MP Ann Winterton opposing liberalisation of the law. There are no separate statistics for abortions carried out in Northern Ireland. The extent of therapeutic abortions carried out in the uncertain legal area of under 28 weeks is unclear.

Audrey Simpson, manager of the Northern Ireland Family Planning Association, said that the legal confusion was reflected in the inconsistent medical practice in the province. "Some gynaecologists would allow abortion for fetal abnormality but not for rape. Others might for rape but not for fetal abnormality," she said.

A study in 1993 by Dr Colin Francome, reader in medical sociology at Middlesex University, found that 61% of gynaecologists in Northern Ireland would carry out an abortion when there was a risk to the mother's health while one in five would not. Just over 60% would carry out an abortion for the victim of a rape while 16% would not.

Ms Simpson is writing to Northern Ireland MPs to ask them to clarify their position on how the law should apply. An estimated 2000 Northern Irish women travel to Britain for abortions every year, according to the Family Planning Association.

Meanwhile, in the Irish Republic on 6 April the Supreme Court will begin considering whether a new bill approving the provision of information on abortion services is constitutional. President Mary Robinson referred the issue to the court after the bill had passed through both the Dail and the Senate. If its constitutionality is upheld the court's ruling would block any future legal challenge on this issue. In an unusual development the chief justice has appointed two legal teams to argue against the senate, one to argue the interests of the fetus and one to represent the woman.

The bill gives legal effect to the result of a referendum in November 1992 that approved the provision of information on abortion. It was one of three referendums held amid the crisis caused by a High Court ban preventing a 14 year old schoolgirl from travelling to Britain for an abortion. The ban was later overturned by the Supreme Court. —ALAN MURDOCH, freelance journalist, Dublin

Children thrive without their greens

Preschool children in Britain today are taller and often heavier than those in the late 1960s, according to a new government survey. But the survey, billed as "the most detailed ever undertaken," shows that today's under 5s manage to achieve this growth in spite of eating too many of the "wrong" foods.

The survey studied a sample of 1675 children aged 1 to 4 years over a four day period. During this time more than 70% of the children consumed biscuits, white bread, non-diet soft drinks, whole milk, savoury snacks, potatoes, chocolates, and chips. Small quantities of leafy green vegetables were eaten by only 39%, while less than a quarter of the children ate raw vegetables and salad.

When the successive age groups were compared the survey identified trends in eating patterns with age: "More of the youngest children ate bananas, commercial infant and toddlers' foods, fish which was neither coated or fried, yoghurt and whole milk, while more of the older children ate white bread, buns, cakes and pastries, ice cream, sugar confectionery, meat products, chips and savoury snacks."

The last similar government survey was in 1967-8, and this latest study says that since then there have been estimated increases in the average heights of under 5s of up to 3.5 cm. The average standing height in this new survey ranged from 86.9 cm for the youngest boys to 102.1 cm for the 3 to 4 year old boys and from 85.3 cm to 101.3 cm for the girls. With regard to average weights, girls aged 2 to 4 years were slightly heavier in this survey round (14.3 to 16.4 kg).

The children's average intakes of thiamine, riboflavin, niacin, vitamin B-6, vitamin B-12, and folate were satisfactory. But iron deficiency was found in almost a quarter of those aged 1 to 2 years. The main

food sources of iron, says the survey, were "cereal products, many of which are fortified, vegetables, potatoes and savoury snacks and meat and meat products."

Food intake was recorded by mothers, who weighed and measured all food for the four days and completed diet diaries. Children in the survey were classified according to the social class of the head of household, and family type was also noted. From these categories it emerged that children from lone parent families were slightly taller than other children, while girls with siblings in lone parent families were slightly heavier than average.

The survey notes several differences in food consumption between children from manual and non-manual backgrounds. Children from non-manual backgrounds were more likely to have eaten rice, wholemeal bread, and whole grain and high fibre cereals as well as cakes and buns. They were also twice as likely to have consumed fruit juice when compared with the children from manual backgrounds and were more likely to be taking dietary supplements. Children from manual backgrounds were more likely to drink tea, which was consumed by a third of all respondents. Lower intakes of most vitamins were recorded for children from manual backgrounds.

The survey was carried out after the government's Health of the Nation white paper identified preschool children as a key group. A related survey of dental health among the same group of preschool children found that one in six had tooth decay. The proportion of those affected increased with age, so that nearly a third of those aged 3 to 4 years had some dental decay.—CLAUDIA COURT, *BMJ*

National Diet and Nutrition Survey: Children Aged 1 to 4 Years is available from HMSO. Volume 1 (Report of the Diet and Nutrition Survey) costs £42; volume 2 (Report of the Dental Survey) costs £14.50.

Health fraud costs billions in US

People who commit health care fraud in the US are unlikely to get caught, a Senate special committee heard last week. Senator Bill Cohen of Maine, chairman of the 19 member panel of the US Senate Special Committee on Aging, whose staff has been investigating health care fraud for the past three years, said that as much as a tenth of the amount spent on health care is lost to fraud and abuse each year.

A parade of witnesses, beginning with Louis Freeh, the director of the Federal Bureau of Investigation, testified before the committee. Mr Freeh said that the bureau had a backlog of 1500 cases to investigate and that "the chances for detection are minimal while the profits are staggering."

Bill Gradison, president of the Health Insurance Association of America, asked Congress to pass laws that would allow insurers to extend their fight against health care fraud. He called for measures to allow insurers to recover fraudulent payments and lawyers' fees. He noted that a survey by the association in 1992 had found that fraud by health care providers accounted for 65% of fraud cases while consumer fraud accounted for 35%.

Nearly half of the cases of fraud among providers concerned fraudulent diagnoses or dates, and a third concerned billing for services not rendered. About 40% of cases of consumer fraud were brought for falsifying claims, and one in four were for false records of employment and eligibility.

A similar survey by the Health Insurance Association of America of fraud in disability income insurance, conducted in 1993, found that 40% of such fraud involved claimants who reported false earnings to

Not their salad days

the insurance company or to the Internal Revenue Service.

Senator Cohen gave some examples of flagrant abuse of health care. Citing one home health care agency, Senator Cohen said, "The list of personal items that were allegedly billed to the Medicare programme is shocking: over \$16 000 in alcoholic beverages at conferences; over \$9800 in personal travel and entertainment for the owner's family; and over \$3200 in golf shop expenses...it is simply outrageous that the federal government is footing the bill."

Other scams disclosed by Senator Cohen included giving angora underwear to Russian immigrants in Brooklyn in exchange for their Medicaid numbers, later used for fraudulent billing; and providing milk supplements for senior citizens in Florida in exchange for their Medicare numbers. The perpetrators of this scheme had arrangements with various doctors who authorised the unnecessary nutritional supplements, costing Medicare over \$14m in fake claims.

In the absence of any statute against health fraud, Senator Cohen will introduce new legislation with bipartisan support during this session of Congress.—FRED B CHARATAN, freelance journalist, Florida

Chickenpox vaccine gets approval in US

The US Food and Drug Administration has approved the first vaccine, Varivax, to prevent chickenpox. The vaccine is based on a live attenuated varicella zoster virus, which was developed in Japan in the early 1970s. Varivax is licensed for general use and brings to 10 the number of diseases among children that can be prevented through immunisation. Each state in the US will decide whether to add chickenpox vaccine to the list of vaccines required for admission to elementary school.

The Centers for Disease Control estimates that four million cases of chickenpox occur annually in the US. Most are in children under 15, when the disease is generally mild. The Centers for Disease Control estimates, however, that more than 9000 hospital admissions a year are related to chickenpox. Each year up to 100 deaths occur from the complications of chickenpox, most of them in young children.

Current studies indicate that the vaccine is effective in 70-90% of cases. The American Academy of Pediatrics and the Centers for Disease Control are working together to develop consistent guidelines for its use. The expected recommendation will be for a single injection of the vaccine for children between the ages of 12 months and 12 years, without the need for routine booster immunisations. Those aged 13 and older, however, will require two doses, four to eight weeks apart. Adverse reactions to the vaccine are reportedly mild, but recipients are advised not to take aspirin for six weeks after the injection to avoid Reye's syndrome.

The Centers for Disease Control said that

clinical trials, which have spanned a decade and involved more than 11 000 people in the US, indicate that a single dose of the vaccine protects most children from chickenpox. Those who did contract chickenpox after vaccination generally had a milder form of the disease than those who had not been vaccinated. The cost of the vaccine will be \$39 (£26) per dose. Cost-benefit studies, which include both direct medical costs and the indirect cost of a parent's lost wages, show that there would be a return of \$5-40 in benefits for every dollar spent on the vaccine.

Dr R Gordon Douglas, a senior physician at Merck, the manufacturer of Varivax, said that clinical trials show that the protection against chickenpox is long lasting. Merck has been studying a group of children for more than nine years and has seen no evidence of waning immunity. In Japan children have been under study for as long as 20 years. Merck plans to continue long term epidemiological studies on tens of thousands of children. Dr Gordon Douglas said that it was not yet known whether the vaccine also protected against shingles (herpes zoster). In published studies in immunocompromised children the occurrence of shingles is lower in those receiving the vaccine than in those infected with naturally occurring varicella virus.

There are no plans to market the vaccine in Britain because it is currently available only in frozen form and freezers are not generally available in family doctors' surgeries in Britain.

Dr Gordon Douglas concluded, "Varivax will protect children against the fifth major childhood viral infection—chickenpox—after measles, mumps, rubella, and polio." —FRED B CHARATAN, freelance journalist, Florida

Ombudsman will rule on clinical complaints

A move towards patient power took place in Britain last week when the government announced that all NHS doctors and their clinical actions are to be brought within the jurisdiction of the health service ombudsman, who will adjudicate on complaints by patients and their relatives about their treatment.

At present the actions of family doctors, as well as matters of clinical judgment, are outside the ombudsman's scrutiny, which is confined to looking at administrative complaints.

The decision by the health secretary, Virginia Bottomley, to bring all these complaints within a revamped NHS complaints system took most doctors by surprise, and the BMA expressed its concern at crucial points of detail still to be agreed.

The inclusion of general practitioners and clinical complaints within the ombudsman's ambit will be the most radical extension to the office since its inception 23 years ago and will require legislation to bring it into effect.

The ombudsman, health service commissioner William Reid, estimates that he will have to handle an extra 1000 complaints a year, almost doubling his workload.

New "simplified and fairer" NHS complaints procedures are detailed in a booklet, *Acting on Complaints*. They combine recommendations by Professor Alan Wilson of Leeds University and the Commons select committee on the ombudsman.

Introducing the changes Mrs Bottomley

A child with chickenpox could soon be a rarity

declared the NHS to be no longer a "like or lump it" service. Patients had to be in the driving seat and know how to go about making a complaint.

The new system is due to come into effect on 1 April next year. A two stage process will apply to all complaints about NHS treatment.

Stage one will provide a quick and informal conciliation on the spot in the hospital or surgery or by written explanation within four weeks, with hospitals' responses signed by the chief executive. Detailed complaints procedures for general practice have still to be decided.

Stage two is for complaints that cannot be resolved by the providers of services. It entails a further review by an investigating panel, with a lay chairperson and a majority of members independent of the provider. The decision to convene a panel will be made by the health authority or trust. Independent clinical assessors will advise when needed.

The ombudsman remains at the apex of the system, after the internal NHS procedures have been exhausted. It is proposed to extend the ombudsman's jurisdiction to cover clinical complaints against all NHS staff and against family health service practitioners—namely, family doctors, dentists, opticians, and pharmacists. It will end the present situation, in which all complaints against family doctors are treated as disciplinary matters.

Mrs Bottomley said: "This will make life much better for GPs, whose present system has added to their stress." Dr John Chisholm, joint deputy chairman of the BMA's general practitioners' committee, broadly welcomed the changes but said that he would have preferred to see a doctor as one of the members of the stage two panel considering complaints in primary care. He viewed the involvement of the ombudsman in matters of clinical judgment "with some concern."

Overall, the new complaints procedure will be concerned only with resolving complaints and not with discipline. Complainants will have a time limit of one year in which to complain.

Mr James Johnson, chairman of the BMA's consultants' committee, said that he regretted that the government seemed to be moving towards a "more legalistic process."

"The new proposals appear to contain little to safeguard them from being used to rehearse possible future court action," he said. He argued that giving NHS trusts the responsibility for organising complaints panels was further evidence of the break up of a "national" health service.

While recognising the need for lay involvement, Mr Johnson said: "Ultimately it is only the independent clinical assessors who can make judgments about clinical decisions taken by other doctors." —JOHN WARDEN, parliamentary correspondent, *BMJ*

Acting on Complaints is available free from DH Customer Service, HMSO, Oldham Broadway Business Park, Broadgate, Chadderton, Oldham OL9 0JA.

Snorting on the stairs

Report paints picture of global use of cocaine

The pattern of cocaine use around the world varies so greatly that it is impossible to describe the average user, says a new report from the World Health Organisation. The report, the result of the largest ever global study on cocaine, says that snorting of cocaine hydrochloride is by far the most popular form of use.

Information was collected from 22 cities in 19 countries, and the report cites some countries, notably Australia, Bolivia, Canada, and Colombia, which are now examining a range of options to legalise and decriminalise the personal use of cocaine. The studies identified strict limitations to drug control policies that rely "almost exclusively on repressive measures." The report says: "Current national and local approaches which over emphasise punitive drug control measures may actually contribute to the development of health related problems. An increase in the adoption of more humane, compassionate responses such as education, treatment and rehabilitation programmes is seen as a desirable counterbalance to the over reliance on law enforcement measures."

Although snorting is by far the most pop-

ular method for cocaine users, others smoke coca paste and crack, says the report, and still others inject cocaine hydrochloride. "Generally cocaine users consume a range of other drugs as well. There appears to be very little 'pure' cocaine use. Overall, fewer people in participating countries have used cocaine than have used alcohol, tobacco or cannabis. Also, in most countries, cocaine is not the drug associated with the greatest problems."

The report acknowledges the range of mental health problems associated with cocaine use and says: "There is a complex relationship between cocaine use and crime, particularly theft and violence."

Most authorities agree, says the report, that it is unrealistic to expect to eradicate the use of cocaine and other drugs. But it says that harm from that drug use need not be inevitable. "In most participating countries, a minority of people start using cocaine or related products, use casually for a short or long period, and suffer little or no negative consequences, even after years of use. This suggests it is possible to reduce, if not entirely eliminate, harmful cocaine use."

The report urges the WHO to develop a five year programme of activities "to reduce the level of cocaine-related harm throughout the world." It also wants the organisation to provide support and assistance to countries such as those in the west coast region of Africa, which showed evidence of emerging problems related to use of coca products.

The report says: "WHO should encourage member states to examine cost effective ways to increase access to existing drug treatment services for groups with special needs, such as prisoners, ethnic minorities, street children, sex workers and other socially marginalised groups."—CLAUDIA COURT, *BMJ*

The WHO/UNICRI Cocaine Project Briefing Kit is available free from Programme on Substance Abuse, WHO, 22 Avenue Appia, CH-1211 Geneva 27, Switzerland.

Hospitals embrace police protection

A police station has been opened inside a Welsh hospital in an attempt to prevent thefts and assaults on staff. Swansea's Morriston Hospital now has a police room and the services of Police Constable Gareth James, backed up by regular visits from other Swansea police, who are encouraged to drop in during their breaks.

According to PC James, who is a trained community policeman, hospital police work

is not usually dramatic. "I deal mostly with simple walk in thefts, auto thefts from the parking lot, and things like that. Also we can use the room to interview people if there's a bad road traffic accident or assault."

PC James will patrol the corridors and grounds of the hospital. He is not convinced, however, that violence poses a major threat to patients or staff: "It's all been blown a bit out of proportion," he said. "I think mainly the hospital wanted a bit of publicity to educate the sort of people you sometimes get in all casualty wards, especially after drinking hours." So far PC James has made three arrests, which have yet to come to trial.

The police room is part of a continuing security programme at Morriston Hospital, which includes video cameras at all entry points and full time security guards. The hospital also plans to fence off the wider grounds in an effort to reduce car crime on the premises. These measures have reduced the number of reported crimes by a third. In 1993 the hospital had 763 reported incidents, including 17 assaults, 88 other "acts of aggression," and 192 thefts. In 1994 there were 450 incidents, including seven assaults, 71 acts of aggression, and 118 thefts.

Contrary to reports in the national press, Morriston is not the first hospital to intro-

duce a police room. The Northern General in Sheffield has had a similar arrangement for three years.

The Department of Health does not compile statistics on violence or other crime in hospitals. Both the BMA and the Royal College of Nursing published reports on the problem in the late 1980s, but no comprehensive research has been done since then.

The National Association of Health Authorities and Trusts has no figures for crime in hospitals either but is concerned about recent incidents, most seriously the kidnapping of babies from maternity wards. Barbara Connah, spokesperson for the association, said that a range of options was being considered, such as tagging of babies, video surveillance, and taking lists of visitors to maternity wards. A report on these issues could be expected at the end of April.

Tony Richards, deputy chief executive at the Morriston Hospital, said that patients' rights would not be infringed. "We remain very aware of patient confidentiality," he insisted. Although the police room has facilities to breathalyse people as well as interview them, he said that this was primarily for patients brought to hospital by police. "It's sort of a one stop service," he said.—OWEN DYER, freelance journalist, London

Focus: Westminster

Ombudsman in a white coat

It would be intolerable," said the health secretary, "for doctors to face a multiplicity of complaints procedures on clinical matters through the courts and the General Medical

Council as well as the perfectly satisfactory procedures for general practitioners." So said Sir Keith Joseph in 1973, when he announced that the newly created British health service ombudsman would have no jurisdiction over general practitioners or any doctor when exercising clinical judgments.

But what was intolerable in 1973 is eminently tolerable in 1995. Today's health secretary, Virginia Bottomley, has decided that, one year from today, the jurisdiction of the ombudsman will be extended to cover clinical complaints and the services of GPs (p 824). The surprise of the announcement is matched only by its implications. Back in 1973 Keith Joseph was quite frank that the decision to bar the ombudsman from clinical matters was taken "after discussion with the medical profession." The NHS clinical complaints procedure that came later remained so tightly in the control of doctors that patients felt the cards were stacked against them.

Subsequently, views about handing the

process over to the ombudsman were ambivalent, while academic studies suggested that any attempt to overcome medical objections to lay participation would require "considerable political determination." In the event it needed a minimum of political will. Mrs Bottomley's matter of fact announcement caused few ripples and is surely further evidence of the embattled condition of the medical profession.

The consequences of the decision will not be trivial. The present ombudsman, William Reid, estimates that clinical complaints against doctors will run at well over 1000 a year. At present he rejects about 400 such grievances each year as being outside his jurisdiction. The workload involved will probably mean that the functions of the parliamentary and health services ombudsman (until now the same person) will have to be separated.

But the ombudsman's jurisdiction over clinical complaints may not open the floodgates in the way that many clinicians fear. For a start, complaints will have to be screened to weed out the trivial and the disguised litigants (the ombudsman does not investigate cases where there is a remedy in the courts, though this is a grey area). Mr Reid thinks that there will need to be professional input into the investigation of clinical complaints. Expert opinion is unavoidable. A clinical investigation would probably be

conducted by a team of doctors and a lay member of the ombudsman's staff.

Doctors' leaders on the BMA's Central Consultants and Specialists Committee see some advantages of a clinical complaints system run by the ombudsman. It would be national and would operate on strict criteria. It would involve professional screeners and assessors, who would have the main role of judging the complaint, though with lay involvement. But it would also result in published criticisms of individual doctors. The committee of MPs who shadow the ombudsman seem to delight in humiliating any consultant unfortunate enough to appear before them. They are hailing the extension of the ombudsman's powers as a victory for their crusade.

Much detail remains to be settled before the enabling legislation due at the end of this year. For example, there is an uneasy overlap between stage two of the proposed NHS procedures and recourse to the ombudsman. The danger is of a complaints bureaucracy that puts complainants through too many hoops and is costly in clinicians' time. But the chance remains for the ombudsman's office to achieve with clinical complaints a degree of justice for patients and influence on the NHS that it has accomplished with distinction in other areas for the past 22 years.—JOHN WARDEN